ALVAREZ & MARSAL
HEALTHCARE INDUSTRY GROUP

Report of the Independent Consultative Expert (ICE)

Monthly Progress Report – June, 2012

on

Parkland Health & Hospital System

Dallas, Texas

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Submitted To:

Centers for Medicare and Medicaid Services
and **Parkland Health & Hospital System**

Submitted By:

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Summary of Progress in June 2012

Alvarez & Marsal Healthcare Industry Group LLC (A&M) is serving as the Independent Consultative Expert (ICE) under the Systems Improvement Agreement (SIA) between Parkland Health & Hospital System (Parkland) and the Centers for Medicare and Medicaid Services (CMS). On February 29, 2012, A&M delivered a Corrective Action Plan (CAP) to Parkland, as required under the SIA. This CAP was approved by CMS and was subsequently accepted by the Parkland Board of Managers on March 8, 2012.

Under the SIA, the ICE is required to present monthly reports to CMS on the progression and status of the CAP, including identification of problems that may jeopardize the successful implementation of the CAP and actions underway to address those problems. This report constitutes A&M's fourth report on Parkland's progress under the CAP. By agreement with CMS, the "start date" for timelines and deadlines under the CAP was set as March 19, 2012.

During the month of June Parkland continued to make progress in meeting most of the deadlines established in the CAP for the month of June. Since the implementation of the CAP on March 19, 2012 a total of 281 tasks have been completed.

Significant goals met in June included:

- Completing several analyses and studies related to patient volumes in multiple care settings (Emergency Department, inpatient and outpatient clinics), which will assist in designing and implementing additional measures to improve patient access and throughput and potentially increase capacity.
- Completing a significant study and report on case management, discharge planning and related social work services at Parkland.
- Commencing electronic medical record (EMR) enhancements to assist in safe medication management, administration and medication reconciliation.
- Revising "crash cart" management, and validating through audit crash cart accuracy. The accuracy of crash cart stocking was a significant issue and deficiency in our April and May report cards. As outlined elsewhere in this progress report, significant improvement was made in June regarding "crash carts" stocking accuracy.
- Creating and rolling out an informational campaign on: patient safety, infection prevention and patient rights.

Our April and May reports found continuing concerns with: 1) recruitment of additional, permanent physician and administrative personnel in the psychiatric units, particularly the Psychiatric Emergency Department (PED) to provide consistent physician coverage levels; and 2) delays in moving towards expansion and revisions to the Medical Staff peer review and OPPE (Ongoing Professional Practice Evaluation) process.

With respect to delays in CAP implementation in June, challenges continue to exist in meeting the CAP goals to stabilize and transform psychiatric care. The Psychiatric service action stream made only minimal progress in June with regard to the two most important goals of securing permanent administrative leadership and consistent physician coverage.

One of the key CAP action items is obtaining additional, consistent physician staffing in the Psychiatric Emergency Department (PED). In early June the Hospital, via its medical school partner the University of Texas Southwestern Medical Center (UTSW), executed a contract to obtain locum tenens psychiatrists for the Hospital's Psychiatric Emergency Department. The Hospital and UTSW also amended its faculty staffing contract in June to include the recruitment of additional permanent psychiatrists to staff the Hospital's PED and ED. However, as of the end of June, the additional staffing was not yet on-site. Additionally, during the month of June the Hospital was required to terminate its interim director of psychiatric services because of delays in that person obtaining a current Texas RN license. This termination has further delayed the goal of obtaining consistent leadership and management of psychiatric care services.

With respect to the changes and revisions to Parkland's Medical Staff's peer review and Ongoing Professional Practice Evaluation (OPPE) program for medical staff members, while some progress was made in June, significant work remains to be done on this initiative, particularly with regard to the Peer Review scoring system and initiating several OPPE pilot programs in key departments.

This report marks the third full month under the CAP, which is the halfway point for many of the initiatives under the CAP. It also marks the ninth month of Parkland's oversight under the SIA and five months since A&M delivered the "Gap Analysis" report to the Hospital. While we continue see a good level of dedication being exhibited by most of the Work Stream Leaders (WSL) and Action Stream Leaders (ASL) under the CAP and the work of their teams, we continue to be concerned by the number of patient care, patient safety and adverse events that are continuing to occur at Parkland despite the implementation of the CAP, the daily presence of A&M as the Independent Consultative Expert and numerous State visits regarding adverse patient events. Throughout May and June we continued to be made aware of adverse quality and safety events including: wrong site surgery, medication errors, patient elopements and EMTALA (Emergency Medical Treatment and Labor Act) compliance issues.

Although the WSLs and ASLs have been engaged in completing tasks and activities under the CAP, the recurrence of these types of safety and care issues suggest that changes in policies, procedures, additional training, messaging, etc. are not yet driving the level of change throughout the organization necessary to mitigate occurrence of these kinds of events.

We believe that an underlying reason for the continuing problems in these areas can be traced in part to the level of engagement in transforming quality and culture at Parkland demonstrated by some members of the Hospital's senior managers and leaders and the lack of background for

several of the managers or leaders to oversee and drive a true operations "turnaround" situation. We have shared with the Board of Managers (BOM) our continuing concerns with the ability of some members of the management to effectively lead the organization through the CAP and a "turnaround" in all operations and affect the needed quality and cultural changes.

With the departure in July of the Chief Financial Officer – who has proven to be an effective proponent of the CAP initiatives -- Parkland will be further challenged with the leadership it needs to complete the CAP and operational turnaround as well as to continue to improve quality and change culture at Parkland. Although the BOM is far along in commencing a search for a permanent Chief Executive Officer, we have recommended to the BOM that additional interim changes may be necessary if the Hospital is to successfully implement the CAP, "hardwire" all of those changes into day-to-day operations and not only successfully pass a CMS / State full survey, but maintain and institutionalize all improvements to quality of care and patient safety required under the CAP. The BOM has taken our recommendations and the ongoing concerns of its State and CMS regulators seriously and has plans to make the necessary leadership and operational improvements and additions at Parkland to acquire leaders with operational change and turnaround experience.

Significant Activities Completed in June 2012 by Work Stream / Department and Summary of Tasks/Milestones Met on Schedule

The six work stream leaders (WSL) under the CAP -- Governance, Clinical Operations, Access and Throughput, Nursing, Physicians and Quality Assessment/Performance Improvement (QAPI) – continued to work with their teams to meet work stream deadlines. As with previous months, at the end of June, the Chief Implementation Officer (CIMO) and A&M conducted an extensive debriefing with each WSL to review task-by-task, item-by-item of the CAP to determine which goals had been met, and which ones had not. Documentation was provided by each WSL to the CIMO and A&M to document that certain tasks had been accomplished. If the documentation was acceptable as reviewed by A&M, certain tasks were noted on this Performance Report as having been complete.

The definition of "complete" simply indicates the task or initiative is been achieved, but does not indicate the implementation of each has created a sustainable practice or change or impacted performance by a measurable metric.

Key activities during the month of June to implement the CAP included the following:

Access & Throughput Initiatives: The "Bed Czar" concept has been developed, complete with new job description and new procedures. The roll out of this role is scheduled for house-wide

implementation in July. The initiative to bring WISH bed management under ADT is a significant operational change for a service line that has traditionally run independent of many of the organization-wide processes of the rest of the Hospital. Additionally, in the month of June, the following access and throughput activities were accomplished:

- A comprehensive Ambulatory Foot Print analysis was delivered ahead of schedule. The extensive information contained in this document will be a key element in the throughput and flow design of the Emergency Department and COPCs.
- The review of all COPC scheduling patterns and "no show" rates has been finalized with significant opportunities identified to increase available appointments. This is currently being implemented and has the potential to have some impact on the numbers of patients being seen in the ED for prescription refills and follow up.

Care Management: The Care Management action stream has been supplemented by an outside consulting firm (Clinical Intelligence). Although the scope of work of Clinical Intelligence is significantly broader than what the CAP requires, we think it can only be helpful to the organization to streamline patient flow and increase efficiency throughout the organization, as well as assist with providing superior patient care. During the month of June, Clinical Intelligence delivered a comprehensive written assessment, with recommendations, for case management, utilization review/management, social work and discharge planning functions. Clinical Intelligence is now working with Parkland's management to create a work plan and timetable for implementing their recommended changes to Parkland's care management system. The work product and recommendations need immediate and complete support and "buy-in" from Parkland's senior leadership, department and unit leaders involved in inpatient services, and especially from Parkland's Medical Staff and Medical Staff leadership.

Case Management reports that it is now currently assessing 100 percent of admissions through the Emergency Department, however, the quality of that assessment is still unknown. In July, further work will be required to ensure that Case Managers are not only intervening in cases, but effectively assessing patients. Additionally, in July physician advisors will be employed to assist and coach physicians in the ED with admissions.

Contract Services: The Contract Services initiative is progressing but has required extensions on timelines, as outlined in the section below "Summary of Tasks/Milestones Not on Schedule."

Emergency Department (ED)/Emergency Services: The Emergency Services area continues to move forward and is on time with most of its CAP initiatives. Opportunities were identified by the Emergency Department Operations Committee for improvements in processes within the ED Services including redesign of the physical layout, extended hours in the Urgent Care Center

(UCC) and the addition of a physician to the ED triage area. Additional physician staffing was approved in June to place a physician in the revised triage area to assist in timely triage functions.

Plans have also been finalized to create a "results waiting area" to transfer some of the Level 3 patients into a controlled waiting space. Creating this new "results waiting area" should eliminate some of the ED hallway holding as well as crowding of the expanded triage area. This area will also serve as a dialysis holding area for patients awaiting emergent dialysis. It will be a controlled and monitored area to provide higher safety for these patients as well as eliminate the holding in the ED. Construction plans are being completed for the renovations necessary to complete these "results waiting area" and expanded triage areas.

EMTALA policy revisions were completed in June and education has been developed to update education of all employees and physicians on the appropriate procedure. These education and information programs are intended to drive the message beyond just ED employees and staff, and to all Hospital employees, regarding the Hospital's EMTALA obligations and thereby hopefully reduce, if not eliminate, issues of confusion with respect to properly screening, triaging and where necessary treating patients, even if it is known that the patient will ultimately be transferred to another facility (e.g., transfers of infants, children and adolescents to Children's Medical Center or a similar facility.)

Updated ED signage has been received and is being installed to designated locations by the Facilities staff. Tracking of all intake patients is complete in EPIC and monitoring is ongoing.

A new SI/HI (Suicidal Ideation/Homicidal Ideation) screening tool was approved in June by ED leadership, however training and pilot implementation of this tool will not occur until July or August.

Environment of Care: The Environment of Care (EOC) initiatives are complete and in the monitoring phase. Specialized cleaning and repair projects task forces have been deployed and repair/painting projects are being finalized. The EOC rounding has been increased with improved results, however, independent EOC rounding by A&M as noted below continues to identify opportunities for improvements in patient room cleanliness. The EOC Committee has met and reviewed rounding findings, which will be forwarded to the BOM for review.

Governance/Organization: During the month of June, the Board of Managers (BOM) reviewed and accepted a revised "Contingency and Emergency Operations" plan for the Hospital, addressing issues of natural and man-made disasters, mass casualty incidents and regulatory actions. The BOM also gave final approval to a revised Quality Assessment and Performance Improvement (QAPI) plan to meet CMS standards. The BOM was provided with additional updates in June, required under the CAP, on review of outsourced and other contractual arrangements. And, in June several BOM members continued to participate in the new Chief Patient Rights and Safety Officer (CPRSO) recruitment process along with senior leadership.

Human Resources: Mercer Consulting completed the first phase of the Human Resources (HR) project in June -- an analysis of HR functions and policies and procedures for performance management, which included interviews with management, focus group sessions, and a survey of over 400 hospital employees. Results from the analysis will be used to re-design HR in Phase Two of the project, which began in July. However, as noted below in the section: "Summary of Tasks/Milestones Not on Schedule," many of the HR-related CAP initiatives are behind schedule.

Infection Prevention: The Infection Prevention action stream initiatives are showing signs of progress. Newly hired members of the IP team have assisted in changing the dynamics of the workgroup and improving monitoring activities and results. All IP policies have now been reviewed and an extension has been requested for those specific to occupational health until the individual hired for this area is onboard and has an opportunity to review. Hospital-wide IP education and monitoring is ongoing and improving but still not at the desired level. The IP Department also launched a hand sanitizer re-distribution action plan in June to address issues raised by staff about hand sanitizers not being conveniently located inpatient care areas.

Jail Health Services: Jail initiatives related to CAP for the month of June were implemented on schedule and audits are demonstrating compliance and sustainability. There is an issue outside of this work stream related to a pharmacy issue due to disparate EMR systems which is currently being addressed.

Laboratory Services: Significant progress was made in June to reform the Critical Values Reporting process. Staff training in the Critical Values Reporting process was completed in June and physician medical staff education material on Critical Values Reporting has been prepared and is awaiting rollout. However, as noted elsewhere in this report, physician education across all work streams has been delayed due to implementation of a technology solution. The auditing process for Clinical Values Reporting was successfully piloted in ED. Full implementation across all care sites is underway. A collaborative team guided by the Patient Safety and Quality Department completed an FMEA (failure mode and effects analysis) process to address mislabeled specimen issues.

Medication Management: Significant improvement was made in June regarding "crash carts" stocking and accuracy. The Hospital's Crash Cart management function was transitioned to the Sterile Processing Department (SPD) in June. Two additional SPD staff members were hired and recruitment for additional staff continues. Rapid Action Team (RAT) and ICU RN's continue to restock carts while the Medical Resources Department (MRD) continues transport duty for crash carts. While good efforts have been made by the ASLs and nursing to ensure a safe environment through fully and appropriately stocked crash carts, this is currently not a sustainable or cost-effective model. The timeline for SPD to assume full responsibility for crash cart management is anticipated to be complete by mid-August. All efforts must be made to hire,

train and monitor SPD staff members to assume these responsibilities for a sustainable change in process.

The unit level cart handoff process, with documentation in the daily log book, has been revised. Crash Cart content and process monitoring demonstrated a 100% compliance level in June. Plans are currently being developed to replace the current paper based tracking system to the electronic system developed and in use by Pharmacy. Full implementation of this plan is anticipated by August 1.

The revised Moderate Sedation Policy implementation continued in June, and will be rolled-out in early July. Additional ACLS classes are in progress as part of this Moderate Sedation Policy roll-out. Staff competency for Moderate Sedation has been identified and documented and Medical Staff credentialing issues on Moderate Sedation privileges – now vs. re-credentialing time – are being resolved.

During the month of June, the Pharmacy Department designed and piloted the revised outpatient settings Medication Reconciliation processes, which utilized a recent Epic EMR enhancement. This revised Medication Reconciliation process is scheduled for full roll-out in July.

Finally, during June all identified patient care areas completed an initial eight week daily departmental Medication Security audit. A majority of the departments demonstrated targeted performance and will move to monthly audits. Those departments with problems identified in their Medication Security audit results will continue daily audits with action plans are underway to address non-compliance.

Nursing: While progress continued in June towards implementing a leading practice nursing acuity system with the selection of McKesson's Workforce Management Nursing Acuity software, nursing is still not staffing to acuity as required in the CAP. A four-month implementation schedule for this new McKesson acuity tracking tool has been scheduled. Nursing did make some progress on using an interim manual solution to staff to acuity, but that progress is not uniform and is not being uniformly implemented across the Hospital. Currently in some units, shift assignments are being adjusted based upon patient acuity and staff's expertise. Significant work remains to be done in implementing an acuity-based staffing model consistently across all Hospital units and departments.

During the month of June, and into July, Nursing Services made some progress with several of the education components under the CAP, including education requirements related to new policies and procedures for "plans of care" and use and continuation of patient restraints. Specifically, during June, the Nursing Work Stream started nurse re-training on having an effective and compliant "Plan of Care" for each patient. These classes are mandatory for all inpatient RNs and LVNs. As of June 18, 2012, 453 nurses successfully completed the classes. Approximately 45 individual classes have been scheduled, with to accommodate nurses working on all shifts including weekends. However, despite the emphasis on training in June, as noted

below in the "Audit and Rounding" section of this report and in the detailed nursing "scorecard," June audits both by nursing and A&M found continuing documentation issues with patient "plans of care" in the medical charts.

Classes to re-educate nursing staff on use and continuation of patient restraints are scheduled to be held from late July through August.

Hand-off procedures are going through another improvement cycle even though Hand off education had occurred earlier this year. Additional types of Hand Off processes were developed to address hand offs from RN to non-clinical staff and nurse to nurse within the unit. Education and communication roll out will occur end of July to mid August.

Patient Rights and Safety: Working with Parkland Police Department and Nursing, the Patient Rights and Safety Department conducted a study of all documented elopements in 2011 and determined reasons for elopement (e.g., breeches in security, caregiver training, etc.). Elopement data findings were presented in Patient Safety and Rights Committee and to the Quality of Care Committee (QCC). One-to-one, patient observation procedure and competencies required for staff have been provided and audits are occurring to demonstrate effectiveness. As noted earlier, elopements continue to be a significant issue at Parkland and continuing work is required in areas such as: identifying patients at high-risk for elopement; providing resources (1:1 observation) to reduce opportunities for elopement; enhancing resources and training for 1:1 observers; exploring opportunities to create additional secured and locked units; and expediting discharge processes to ensure that elopements do not occur because of delays in the patient discharge process.

Physical Medicine and Rehabilitation (PM&R): A plan was developed and implemented in June to address the patient appointment backlog through improved scheduling, streamlining workflow and documentation, and a performance monitoring system with daily, weekly and monthly goals, responsibilities and tools.

Quality/Safety: The Quality and Safety work streams continued to meet CAP objectives in June. A revised QAPI plan was reviewed and approved by the Quality Committee and BOM in June. A Patient Rights/Patient Safety Awareness Campaigns was launched in June for Patients Rights, Hand Offs, and HIPAA. Education materials for Hand Offs for nursing, medical staff and other staff have been developed and waiting for execution to be completed by mid August. Finally, as noted above in the Governance/Organization work stream, recruitment efforts for the new position of Chief Patient Rights and Safety Officer (CPRSO) continued on schedule in June.

Radiology: The Radiology Department continued migration in June from a Radiology Technician to RN-focused care model in the procedural areas in order to enhance professional oversight of patient care and safety relating to: infection control, universal protocol, moderate sedation, and medication administration. Radiology completed an initiative in June to insure properly credentialed provider use of fluoroscopy and set controls in place to promote ongoing

compliance. Staff completed radiation safety annual training, in conjunction with UTSW working through Faculty education process.
Discussions have occurred with management of Imaging/Radiology and senior leadership to develop a plan to address the long wait time and backlog for diagnostic mammography which may be causing a delay in care. The plan is to engage an outside Radiology Physician group to assist with reading of screening mammograms in order to free up the Parkland's Radiologists to be available for the diagnostic readings. Contract discussions have been initiated with the UTSW physicians.

Respiratory Therapy: Respiratory Therapy implemented a new staffing pattern and documentation education related to their plan of care in June that is intended to positively impact missed treatments and documentation quality. Continued monitoring is designed to measure improvement and identify further improvement opportunities for action.

Surgical Services, Perioperative, Anesthesia, and Procedural Department Specific Initiatives: During June, Surgical Services finalized policy revisions for: Universal Protocol, medication administration, surgical attire, and site markings. Daily monitoring of these policies occurred in June through direct observation. June audits demonstrate targeted level compliance for all indicators in nearly all units. Some procedural areas were identified to require additional education and training relating to these practices. Disciplinary action has been taken for continued staff and physician non-compliance. The Hospital has made progress in this area and is committed to hard-wiring these important patient safety practices.

June also saw continued migration from a Tech to RN focused care model in the procedural areas to enhance professional oversight of patient care and safety relating to infection control, universal protocol, moderate sedation, and medication administration. Labor & Delivery revised the sterile field maintenance policy and procedure and direct observation audits demonstrated targeted performance compliance.

Women and Infants Specialty Health (WISH): The WISH initiatives are progressing on schedule. An independent consulting firm, Blue Cottage completed their study related to the transition to Mother/Baby care design, and staffing projections have been finalized. A secondary request was made to Blue Cottage to assess the impact of the physician clinic schedules on the overcrowding of the L&D areas particularly. Staffing plans for service redesign have been submitted to Hospital senior leadership for approval. Partial approval has been received and recruitment is underway for additional staff and leadership positions. New NICU leadership started during the month of June. Construction plans have been finalized and WISH continues to wait for physical plant changes to be complete to implement initiatives related to infant resuscitation and soiled utility spaces.

Summary of Tasks/Milestones Not on Schedule

Several activities have not been completed in June in accordance with the CAP timetables. Tasks not completed in June include the following:

Care Management: As noted above, although the timelines for implementing some of the care management CAP requirements were delayed pending the arrival of the case management consultants, the delays are within an acceptable range given that the case management consultants will be performing an even more extensive review and reorganization of Parkland's case management functions than that contemplated under the CAP. A&M has reviewed the case management consultant's preliminary work plan and work team and believe that they are now on course, with modified deadlines, for implementing the case management, discharge planning, utilization review and management and social work assistance changes required under the CAP.

As stated earlier, although inpatient admissions through the ED are now assessed by a Case Manager, the quality and depth of that assessment is unknown. The function of case management in ED is not fully developed at this time.

Contracts: As noted in the section above, the Contract Service initiative is progressing but has required extensions on timelines. There have been multiple meetings and calls to review the metric components of Parkland metric and Departmental metric with leaders to provide clarity and direction. The Contract Service initiative now seems to be moving forward and all contracts have been loaded and communications sent to departments responsible for contracts to provide or procure metrics. Additional resources have been secured to assist in securing metrics from vendors. It is unlikely these initiatives will be on schedule, however, even with timeline extensions due to the volume of contracts to address.

Human Resources: In order to address the Human Resources tasks and initiatives within the CAP, Parkland retained the assistance of a human resources consulting firm: Mercer Consulting. Because of the time necessary to interview, select and onboard the consultant team, several Human Resources related tasks are behind schedule. These tasks behind schedule include: redesign of policies and procedures on performance management and progressive discipline; education regarding these new policies and procedures, recruiting; and, expanding the role of HR "business partners." We believe that many of these initiatives can ultimately be put back on track with the assistance of the outside consultant, Mercer Consulting.

Medical Staff: While significant efforts were made in June to continue to create a plan to revise and improve the Medical Staff's procedures for peer review and Ongoing Professional Practice Evaluation (OPPE), a significant amount of work is necessary to implement not only a new OPPE plan, but an effective peer review process. In an endeavor to revise the OPPE system, it

has become clear that the entire process of physician peer review needs to be revamped. With over 1,600 Medical Staff members, this is a significant undertaking, and the Hospital must commit all necessary resources to assist the Medical Staff in implementing the new peer review/OPPE plan. The Hospital has struggled with this action stream, therefore A&M has supported the team with additional consulting expertise to assist with development of a Professional Staff Quality Management plan. This plan completely overhauls the process used to collect data for physician performance and peer review.

The peer review/OPPE plan has been provided in detail to the Chief Medical Officer (CMO) but has not yet been approved. The plan has also been presented to the PCRC (Patient Care Review Committee) for approval of a new peer review scoring system. Members of the committee have not yet approved the new scoring system. The new methodology must be approved by the Medical Executive Committee (MEC). Interviews with individual members of the committee will be held in July to address concerns. Although the plan has several physician champions, without the support of the CMO, this is a time consuming and difficult process.

Because of the enormity of the process overhaul, five departments were identified to begin a pilot program. These departments are Surgery, Psychiatry, Emergency Department, Cardiology, and Anesthesiology. If the OPPE overhaul process is to continue on schedule to a January 1, 2013 implementation, this pilot program for these five departments must move forward.

Nursing: Although changes to Epic have been made and education has been instituted, and an audit tool has been developed, as of the end of June, (the second version) patient restraint policies had not been finalized. Physician leadership is still required to review the policy and provide education for physicians regarding new policies.

As noted in the section above, "acuity-based" staffing has not yet been fully implemented – even through a manual, paper-based system. Currently nursing is staffing to unit specific grids designed to volume & average acuity and balancing shift assignments based upon patient acuity and staff's expertise. Med/Surg units appear struggling to adopt a staffing to acuity model due, in part, to an ineffective float pool and limited resources. A comprehensive plan for a well-managed float pool of nursing personnel will need to be developed.

Initiatives to properly staff the House Supervisor function are behind schedule, which adds to the inconsistency of nurse staffing and scheduling.

Finally, as noted above, while significant training occurred in June regarding proper creation and documentation of plans of care, chart audit results in June suggest continuing deficiencies in properly creating and documenting plans of care.

Patient Safety: A standardized rounding and tracking process as a method of collecting data for adverse patient events has been presented to the action stream team members but is behind

schedule on implementation. This 'tracer tool" will track high-risk patients from admission through discharge and post acute care to ensure proper care through the patient experience.

Physician Engagement: Initiatives in this action stream are generally behind schedule. A planned audit of the effectiveness of the AMCOM system was determined to be flawed after a six week period. A new plan has been conceptualized by the team. Development and implementation of the plan is scheduled to occur in July. In the meantime, A&M will begin to round on nursing floors in July to determine how effective the system is to enable nurses to reach the appropriate physician. These audits will also address the ability of the nurse to reach the appropriate treatment team. The action stream group has developed a process for updating treatment teams within the Epic system, and education for the new process has been developed as well. The education is scheduled for the first week of July to coincide with the new round of Residents.

Psychiatric Services: While some initiatives and goals were achieved in June, the Psychiatric Services work stream continues to be delayed in meeting several of the important CAP timelines and goals, particularly around continuity of leadership.

One of the key action items is obtaining additional, consistent physician staffing in the Psychiatric Emergency Department (PED). In early June the Hospital, via its medical school partner the University of Texas Southwestern Medical Center (UTSW), executed a contract to obtain locum tenens psychiatric physicians for the Hospital's Psychiatric Emergency Department. The Hospital and UTSW also amended its faculty staffing contract in June to include the hiring and recruitment of additional permanent psychiatrists to staff the Hospital's PED and ED. However, as of the end of June, the additional permanent staffing was not yet on-site. Two locum physicians have been hired to begin in July and August respectively.

During the month of June the Hospital was required to terminate its interim director of psychiatric services because of delays in that person obtaining current Texas nursing license. This termination has further delayed the goal of obtaining consistent leadership and management of Parkland's psychiatric care services.

The placement of a Psychiatric Team within the Main ED (Team C) has been a significant improvement in the coverage of the Main ED for expedited disposition. The SI/HI screening tool was implemented in the PED as a pilot but delayed in the Main ED due to verbiage changes requested. The changes have been finalized and implementation for Main ED will be initiated. Role and responsibility job descriptions have been finalized and training completed. Audits will be conducted beginning in July to evaluate staff understanding of these roles and responsibilities. Construction plans for temporary PED relocation and remodeling of the permanent PED are final and on schedule for August temporary relocation and remodeling construction.

Resident Supervision: Although the physician members of the Task Force are extremely dedicated and engaged, several of the initiatives in this action stream are behind schedule. The Task Force had been delayed in making decisions relating to procedures and events that require advance approval by an Attending Physician or direct supervision. As a result, education and auditing have been delayed. Final decisions on procedures and events requiring advance approval and/or direct supervision were made in late June. Required development in Epic and IT has progressed and should be ready for roll-out in July. We anticipate that the Task Force will make progress in July in finalizing an audit tool and developing an implementation plan for the audits.

Audits and Rounding

During the month of June, A&M continued to round on all Hospital departments and do some limited auditing to assess whether CAP-required changes were in fact occurring within floors and departments, particularly in the areas of: infection prevention procedures, environment of care and documentation of patient plans of care. Initial A&M audit results suggest there is room for improvement in the areas of Environment of Care, Patient Privacy and Patient Safety.

June Environment of Care audit results from the Hospital audit tools suggest opportunities for improvement still exist in areas of Fire and Life Safety, Environmental Services and HIPAA compliance, and Infection Prevention. EOC rounding conducted by A&M verifies these findings. Specific areas requiring focus will be targeted for July for intense scrutiny.

June audits conducted by Infection Prevention indicate an improvement in hand hygiene, but not as much progress as required at this stage of the CAP.

Chart audits conducted by Hospital and A&M suggest inadequate nursing documentation relating to patient plans of care and assessments. Also noted in chart audits were the absence of proper physician procedure notes and "sign off" on resident related activities.

Level of Engagement

We continue to have been favorably impressed by the dedication that the Parkland BOM has demonstrated towards successful implementation of the CAP. The BOM has directed Parkland's senior management to devote the requisite time and financial resources necessary to implement each aspect of the CAP. This direction has been evidenced by the potential hiring of additional outside consultants in the areas of human resources, case management, WISH and board governance to provide the resources necessary to effect change in those areas.

We also continue to be favorably impressed by the work and dedication of most of the work stream leaders and action stream leaders under the CAP.

We are continuing to address the level of management engagement necessary to plan, institute and complete the important work of:

- Achieving consistent, permanent staffing in the psychiatric services units;
- Care Management Department re-organization;
- Education and training initiatives under all areas of the CAP;
- Revising the Medical Staff OPPE processes and procedures,
- Executive rounding tools and schedule, and
- Implementation of additional oversight and auditing methods for Resident physician supervision.

As noted in the Introductory Section above, however, we remain concerned by the level of engagement by some members of the Hospital's leadership and management in championing and supporting the CAP implementation and in working to create a changed culture of quality and accountability at Parkland. We have shared with the Board of Managers our continuing concern with the ability of several members of the Hospital management and leadership to effectively lead the organization through the CAP and effect the needed quality and cultural changes at Parkland.

Structure of Monthly Report

This Performance Report itemizes each of the Action Items ("Tasks/Initiatives") from the CAP, along with the associated "target date" for completion. Each of these Tasks/Initiatives is then assessed in terms of completion or status towards completion with a Red, Yellow or Green dot. Under this convention "Green" means that a Task/Initiative is largely on schedule for completion. "Yellow" means that a Task/Initiative may be delayed from Target Date completion. The Yellow does not mean that the Task/Initiative will not be completed in the required time, but that redoubled efforts may be necessary to ensure timely completion. A "Red" dot indicates that the Task/Initiative is past the Target Date deadline. A "Black" dot denotes a task or initiative where tracking has not yet started.

Each area of the CAP also has several associated metrics to demonstrate whether the required Task/Initiative has been successful in reaching its desired effect and has been sustainable (e.g., nursing plans of care are consistently documented, or "hand hygiene" audits have consistent positive scores.) We continue to increase the number of audits performed and metrics reported.

Next 30 Days

As the report notes on specific task items, we are concerned that some tasks and milestones may not be on schedule for timely completion under the CAP. Some of these delays have resulted from the need to acquire outside consulting assistance on some of the action plan items. Redoubled efforts and focus will be required in the month of June to ensure that these items are completed under the timetables required by the CAP.

During the month of July, the six work streams – governance, clinical operations, access and throughput, nursing, physician/medical staff and quality – will focus on the following action items and initiatives:

Governance Work Stream:

- Work to complete post-acute community resource assessment;
- Accelerate human resources consulting engagement with Mercer to review policies and procedures and infrastructure within Human Resources functions especially related to recruitment processes;
- Complete vendor decision and begin implementation of information technology solution to support content management and delivery of education and training; and
- Begin in person interviews for Chief Patient Rights & Safety Officer (CPRSO) candidates.

Clinical Operations Work Stream:

- A secondary request was made to Blue Cottage to assess the impact of the physician clinic schedules on the overcrowding of the L&D areas particularly. Preliminary results have indicated opportunities to adjust physician practice patterns and significantly impact the overcrowding, infection risk and staffing issues.
- Complete identification and on-boarding of "locum tenens" and permanent faculty by UT Southwestern Medical School for psychiatric services at Parkland;
- Continue to expand, consistent attending psychiatric services coverage and permanent psychiatric units leadership;
- Accelerate facility renovation and construction plans for Psychiatric ED;
- Implement and audit effectiveness of suicide risk and behavioral quadrant assessment tools;
- Institute training/education and conduct audits within radiology, physical medical and rehabilitation (PM&R) and laboratory, following up on policies, procedures and workflow changes instituted in earlier months under the CAP;
- Evaluate effectiveness of pilot study of pharmacy technicians assisting with medication reconciliation;

- Continued training/education and conduct audits within procedural departments; and
- Examine additional "ownership" model of units with regard to environment of care and infection control for both hospital-based and off-campus locations.

Access and Throughput Work Stream:

- Complete EMTALA (Emergency Medical Treatment and Labor Act) training for ALL employees who encounter/direct patients for Emergency/Urgent Care services;
- Introduce the Interdisciplinary Team model on all inpatient units. These Interdisciplinary teams will provide an essential function to the care of the patient while in the Hospital as well as post-acute care. In addition, lengths of stay will be managed effectively which will improve patient throughput.
- Continue to implement and make operational the "Bed Czar" role;
- Continue to evaluate the actual results of the case management role in Emergency Department;
- Continue to identify opportunities for efficiencies within COPCs; and
- Focus by Environmental Services on one-time equipment evaluation and repairs.

Nursing Work Stream:

- Continue efforts to update and revise all nursing policies, procedures and standards including finalizing changes to policies, procedures and training on proper use and documentation of patient restraints;
- Conduct education/training and audits of practices related to documentation of plan of care, restraints, hand-offs;
- Implementation and auditing of revised role and responsibilities for Nursing Supervisors (i.e., "house supervisors");
- Continue to focus on implementation of staffing to acuity models for ALL nursing units, even if temporarily paper-based staffing systems must be utilized;
- Finalize revisions to competencies for clinical staff; and
- Staffing of SPD for the process and management of "crash carts" and continue audits to 100% accuracy.

Physician Work Stream:

- Accelerate work on OPPE/FPPE re-design efforts including: finalizing the new peer review scoring system, developing department/service specific metrics and working toward goal of five pilot programs;
- Evaluate and analyze organization structure of Medical Staff office;
- Complete "audit tool" for resident supervision auditing program;
- Refine policies and processes related to identification of "on call" Resident and Attending physicians.

Quality & Safety Work Stream:

- Continue with reorganization of Quality Department;
- Implement rounding by Performance Improvement group as a method to collect data for adverse patient events;
- Complete evaluation of the organization structure of Patient Safety;
- Continue refinements of Patient Relations Department data collection and reports;
- Develop a dashboard and track and trend the indicators for "patient rights" and the progress to the target thresholds; and
- Continue work on quality indicators for vendor contracts.

Barriers

We did not encounter major barriers to implementing the CAP in the month of June, however, as noted above in this report we have shared with the Board of Managers our continuing concern with the ability of some members of senior management to lead effectively the organization through the CAP and implement and institutionalize the needed quality and cultural changes at Parkland. For example, we were disappointed in the delays in June in moving forward with the work stream activities in psychiatric services and OPPE/peer review changes.

We believe that we may continue to encounter barriers in the following areas in June that might result in delays to timely completion of CAP tasks and initiatives:

- Ability to roll out training timely given scope of initiatives with education component, current resources and technology;
- "Fatigue" setting in among all key stakeholders in implementation of CAP;
- Competing priorities for managements' time and focus on completing budget;
- Distraction resulting from management personnel changes; and
- Departure of the Chief Financial Officer and efforts to get a new interim CFO transitioned into place.

We will continue to work with the executive sponsors and the Parkland BOM to anticipate these potential barriers and find ways in which to address and eliminate these and other barriers as they may arise.

Summary

We believe that Parkland has continued to make measurable progress in June to implement CAP action items in accordance with the established deadlines. However, what must be emphasized now at this point in the CAP is to "hardwire" changes and institutionalize all of the changes and initiatives to guarantee sustained quality of care and patient safety.

The Hospital is now three months into the implementation of the CAP. Although achievements have been related to specific tasks in the CAP, continued adverse patient safety and quality of care issues in May and June suggest that not all of the efforts in the CAP are resulting in an ultimately safer and higher quality patient experience in all areas of Hospital operations.

Several of the metrics and audits presented in this June report (diagnostic mammography wait times, use of hallway beds in L&D, elopements, medication reconciliation, patient plan of care documentation, and EVS standards) also suggest that not all of the efforts in the CAP are resulting in an ultimately safer and higher quality patient experience in all areas of Hospital operations. Some of these audit results and metrics will improve, we hope, in succeeding months. But ultimately, the message of the importance of the CAP and all of its initiatives must be embraced and led by all in the Hospital's management and leadership positions. For that reason, the Board of Managers must continue to monitor and evaluate whether all of Parkland's senior leaders and managers can effectively lead the Hospital through a successful CAP implementation and successful CMS / State full survey.

Governance (Section 2.01)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
1.01	MEC to prepare a comprehensive plan to implement Ongoing Professional Performance Evaluation (OPPE). Review 5% of Medical Staff OPPE Profiles at conclusion of next eight-month cycle.	Patricia Bergen, MD	5.1	10/31/2012							
1.02	Hospital senior management to revise the Parkland ESD Policy Manual to include written policies and procedures regarding documentation of Teaching Attending Physician oversight of Residents.	Brad Marple, MD	5.3	5/18/2012							Y
1.03	Hospital senior management, in collaboration UTSW and A&M to create a standing rounding, evaluation and auditing process to collect data on Resident oversight.	Brad Marple, MD	5.3	7/30/2012							
1.04	Require quality "dashboard" report from Hospital Quality Department	Jackie Sullivan	6.4	5/25/2012							Y
1.05	Commence reviews of "scorecards" for significant outsourced and contracted clinical services. Design a Board-specific QAPI plan.	Jackie Sullivan	6.4	6/1/2012							Y
1.06	Review and revise BOM committees.	Paul Leslie	1.1	6/8/2012							Y
1.07	Review performance management and progressive discipline implementation plan from Human Resources.	John Dragovits	1.5	6/8/2012							
1.08	Review comprehensive plan to create better communication and coordination among the Hospital's Legal, Compliance, Internal Audit and Quality Departments.	Jody Springer	1.2	6/8/2012							Y
1.09	Review Hospital plan on continuum of care.	Dr. Royer Jackie Stephens	3.5	7/13/2012							
1.10	Appoint Task Force to review Hospital's current Disaster Plan and all other plans indicating how the Hospital and community would respond to rectuion, closure, or diminishment of services or care by Parkland	Paul Leslie	1.1	7/13/2012							

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Percentage of contracts (outsourced vendors) reviewed for quality measures	Contract Svcs		100%			80.0%	85.7%			

Comments

1.03 - Written tool has been drafted but implementation of audit has not been finalized

1.07 - Initiative missed deadline due to Mercer engagement of consultant; good progress underway

1.08 - Need to see proof of weekly and monthly coordinated communication among Legal, Quality, Compliance and Internal Audit either through regularly scheduled meetings, issues briefing memos, etc.

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Human Resources (Section 2.02)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
2.01	Redesign progressive disciplinary policies and procedures and performance management system.	John Dragovits	1.5	5/25/2012							
2.02	Redraft goals of the Leadership and Organization Development Department.	Jody Springer	1.2	5/25/2012							
2.03	Develop education materials for new processes and policies.	John Dragovits	1.5	5/25/2012							
2.04	Conduct training for management and employees.	John Dragovits	1.5	7/13/2012							
2.05	Expand the role of Business Partner, require they take a more active role with front-line managers and supervisors.	Jody Springer	1.2	5/25/2012							
2.06	Business partners to audit evaluations for the next two evaluation cycles.	John Dragovits	1.5	9/14/2012							
2.07	Evaluate current HR staffing model.	Jody Springer	1.2	7/13/2012							
2.08	Analyze resource allocation within HR Department.	Jody Springer	1.2	7/13/2012							
2.09	Develop Parkland employee retention strategy.	John Dragovits	1.8	9/14/2012							
2.10	Develop policies, procedures and training material regarding employee retention strategy.	John Dragovits	1.8	9/14/2012							
2.11	Develop master list of all competencies required for each department by job code.	Jim Johnson	1.6	9/14/2012							
2.12	Review and revise LMS system to ensure all required competencies are reflective in the system.	Jim Johnson	1.6	7/13/2012							
2.13	Review all personnel files for completeness.	Jim Johnson	1.6	9/14/2012							
2.14	Educate employees on proper and complete paper work (licensure/certifications).	Jim Johnson	1.6	6/4/2012							Y
2.15	Ensure accurate and complete paper work is immediately forwarded to Nursing Administration.	Jim Johnson	1.6	7/13/2012							
2.16	Form standing committee to review polices and procedures with representation from administrative, clinical, and support areas	John Dragovits	1.5	4/6/2012							Y
2.17	Develop policies and processes to be used for HR policy review.	John Dragovits	1.5	4/27/2012							Y
-	Frame desired culture as the foundation for all HR related elements of the Action Plan	Linda Wilkerson John Dragovits	1.4	7/13/2012							

Human Resources (Section 2.02)

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Percentage of supervisors (and above) who have attended training administred by clinical education	House-Wide	100%						
2a	Evaluation scores on histogram or bar chart for each department (annual evaluations) - below expectations	HR	5.0%	4.1%	N/A	N/A	N/A		
2b	Evaluation scores on histogram or bar chart for each department (annual evaluations) - meets expectations	HR	55.0%	33.9%	N/A	N/A	N/A		
2c	Evaluation scores on histogram or bar chart for each department (annual evaluations) - above expectations	HR	40.0%	65.7%	N/A	N/A	N/A		
3	Percentage of competencies/job descriptions completed	HR	100.0%						
4	Percentage of licensing validations presented prior to the day of hire	HR	100.0%						
5	Time from occurrence to corrective action signed by employee (days) [1]	HR	20			20.9	18.3		

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1a	Turnover Rate (%) - Nursing [1]	HR	16.5%	14.5%	16.3%	13.6%	19.0%	24.9%		
1b	Turnover Rate (%) - Total [1]	HR	15.0%	14.1%	16.0%	13.3%	16.8%	17.5%		
2	First year turnover rate [1]	HR		20.0%		17.3%	19.8%	19.1%		
3	Percentage of employees (annually) who leave for stated reasons of better opportunity (compensation, job duties, benefits)	HR	35.1%	25.0%	29.0%	35.6%	26.7%	36.8%		
4	Employee satisfaction scores	HR	76.0%							
5	Percentage of competencies updated on/before due date	Clinical Edu		100.0%						
6	Number of corrective actions [1]	HR	40	N/A	38	34	29	54		
7	Percentage of current licensure [1]	HR		100.0%		100.0%	98.8%	98.8%		
8	Time for recruiting to fill an open job positions [1]	HR	59.9	55.0	60.1	62.2	66.3	62.9		
9b	Absentee/Tardiness occurrences (as a percent of non exempt employees) [1]	House-Wide			31.2%	37.0%	34.2%	30.7%		

Comments

2.01 - 2.05 - Initiatives are delayed due to dependency on completion of outside consultant work
2.12 - Initiative is projecting a missed deadline since the new LMS system is in contracting
2.13 - Need to establish definition of "complete file"
2.17 - Initiative delayed due to the engagement with Mercer

1. Audit/metric result is self reported. A&M has not yet validated this figure.

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Access/Throughput (Section 2.03)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
3.01	Review of scheduling templates and actual scheduling patterns at COPC sites in comparison with best practices for teaching clinics along with analysis of schedule utilization versus capacity by clinic	Jessica Hernandez Holt Oliver, MD	3.6	6/8/2012							
3.02	Conduct analysis of no show rates by clinic, day, session, and provider.	Jessica Hernandez Holt Oliver, MD	3.6	6/8/2012							Y
3.03	Conduct a physician productivity analysis based upon a review of current process and development of analytics.	Jessica Hernandez Holt Oliver, MD	3.6	6/8/2012							Y
3.04	Document current process workflow diagrams, identify barriers to throughput and develop solutions that might increase productivity and result in additional capacity	Jessica Hernandez Holt Oliver, MD	3.6	7/13/2012							
3.05	Review ED utilization and most common diagnoses by patient admission times to analyze opportunities for changes or improvements in COPC hours of operation	Lonnie Roy	3.1	7/13/2012							
3.06	Develop the post-acute care network.	Dr. Royer Jackie Stephens	3.5	7/13/2012							
3.07	Case Management to generate a study report by physician or service showing average time of discharge for patients and physicians or services consistently discharging patients late in the day.	Robin Stults w/ External Resources	3.4	6/12/2012							Y
3.08	Chief Medical Officer to meet with the Medicine and Critical Care Service Chiefs and Hospital Directors to determine barriers to earlier discharge of patients on the units and develop a solution.	Robin Stults w/ External Resources	3.4	8/15/2012							
3.09	Conduct a physician productivity analysis based on agreed upon industry standards.	Jessica Hernandez Holt Oliver, MD	3.6	5/11/2012							Y
3.10	Conduct a feasibility study for a dedicated observation unit	John Dragovits	1.7	7/13/2012							
3.11	Conduct a feasibility study to determine the best use of 4SS space	John Dragovits	1.7	7/13/2012							
3.12	Conduct a study to determine appropriate expansion of the dialysis unit.	John Dragovits	1.7	7/13/2012							
3.13	Design “Bed Czar” concept to report to ADT	Miriam Gomez	3.3	7/1/2012							
3.14	Establish strict standards regarding communication and patient placement timelines with ADT to enhance patient placement.	Miriam Gomez	3.3	8/1/2012							
3.15	Complete an assessment of the current flow of acute emergent dialysis patients through the emergency department, including potential delays, arrival time patterns, and boarding in the Emergency Department.	Kim McCloud Linda Licata	2.6	6/1/2012							Y

Access/Throughput (Section 2.03)

#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
3.16	Define a patient flow process that will reduce and/or eliminate boarding of dialysis patients in the emergency department.	Kim McCloud Linda Licata Barbara Mims	2.6	6/15/2012	●	●	●	●			Y
3.17	Define and obtain approval for resources necessary to implement process, including expansion of serivces.	Kim McCloud Linda Licata	2.6	7/1/2012	●	●	●	●			
3.18	Develop protocols and obtain resources for implementation of defined patient flow process.	Kim McCloud Linda Licata Barbara Mims	2.6	8/1/2012	●	●	●	●			
3.19	Fully implement patient flow process and expansion of services to eliminate boarding of dialysis patients in the emergency department.	Kim McCloud Linda Licata Barbara Mims	2.6	9/1/2012	●	●	●	●			

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Projections for percentage (or appointments/hours) of capacity to be gained through physician productivity and/or improved throughput efficiency								
a	Family Medicine	COPC	14%						
b	Internal Medicine	COPC	10%						
c	Geriatrics	COPC	4%						
2	Number of additional appointments to be gained by factoring in 'no show' by clinic session	COPC	500						
3	Percentage of observation patients outside of observation unit	ADT		57.0%	56.0%	57.0%	60.0%		

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of days to next third available appointment (primary care, geriatric, pediatrics, medicine and surgical specialties)	Clinics								
2	Utilization rates by session by clinic (hours of activity/hours of capacity)	Clinics								
3	Percentage of discharges (medicine, surgery) by 11:00 a.m.	Care Mgmnt				6.2%	6.4%	5.0%		
4a	No show rates - Surgery	Clinics								
4b	No show rates - WISH	WISH								
5	Physician (clinic, Hospitalists) productivity (based upon RVUs)	Med Staff								
6	Number of patients on wait list for clinics	Clinics				21,922	22,623	22,623		
7	Number of bed days occupied by observation status (by unit)	Care Mgmnt			1,713	1,928	2,518	2,721		
8	Average bed turn time (hours:minutes)	EVS		1:00	1:06	1:13	1:18	1:13		
9	Average minutes of boarding in ED									
a	Main ED	ED					129.6	126.4		
b	ICC	ED					100.6	126.2		
10	Average number of dialysis patients in Main ED at 6AM	ED				11.0	10.9	12.7		
11	Average Length of Stay (1 month lag)	Care Mgmnt	5.0		5.1	5.1	5.3	5.2		
12	Percent inpatient occupancy (census) by division	ADT				84.5%	85.0%	84.1%		
13	Bed Request to Bed Assign, average from bed assigned to patient in bed	EVS			69	62	67	63		

Access/Throughput (Section 2.03)	
Comments	
3.01 - Initiative missed deadline due to increasing scope of work to include Specialty Clinics 3.06 - Progress continues on the development of the post acute care network. Data has been collected and priority of need has been established. Data currently collected by Case management will be incorporated into the final report which will include current state and recommendations. 3.08 - No formal efforts have been made within the context of the CAP to engage Medical Staff in conversations related to earlier discharge of inpatients 3.10 - 3.12 - Work continues on the hospital-wide bed study which is intended to right-size beds per service line based on historical data. Most data has been collected and analyzed. In July, stakeholders will convene to arrive at a recommendation for senior leadership approval. 3.13 - An initial two-week pilot of the bed czar concept was completed with four units in the hospital. The results from that program were used to complete the hospital wide plan which will be rolled out in July	Task/initiative largely on schedule for completion Task/initiative may be delayed from Target Date completion Task/initiative is past the Target Date deadline Initiative tracking not yet started

Provision of Care (POC) (Section 2.04)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
4.01	Define nursing supervisor role expectations and competencies.	Jackie Brock John Raish	4.3	4/20/2012							Y
4.02	Revise job description to meet role expectations.	Jackie Brock John Raish	4.3	4/27/2012							Y
4.03	Meet with HR leadership to determine most appropriate and fair way to move forward in establishing a broader more accountable house supervisor role.	Jackie Brock John Raish	4.3	4/27/2012							Y
4.04	Meet with existing nursing supervisors and explain new responsibilities and go forward plan.	John Wood Mary Eagen	4.1	5/4/2012							Y
4.05	Initiate new role expectations.	Jackie Brock John Raish	4.3	9/14/2012							
4.06	Conduct a comprehensive review of the nursing structure under the direction of the new CNO.	John Wood Mary Eagen	4.1	3/30/2012							Y
4.07	Develop internal and external recruitment plan for new organizational structure.	Jackie Brock John Raish	4.3	5/11/2012							Y
4.08	Written Timeline conversion to new organizational structure.	John Wood Mary Eagen	4.1	4/13/2012							Y
4.09	Review of all nursing practice standards, policies, and procedures for compliance and relevance. Upon review of nursing standards, policies and procedures, a list of gaps identified must be written so there is a documented source to help drive educational plans and strategies.	Barbara Mims Valerie Harvey	4.2	8/31/2012							
4.10	Revise policies/procedures and nursing standards to reflect best practices, as appropriate.	Barbara Mims Valerie Harvey	4.2	9/14/2012							
4.11	Develop a house-wide educational plan to correct the current deficiencies in patient care.	Barbara Mims Valerie Harvey	4.2	9/30/2012							
4.12	Develop nurse leadership competencies for all managers.	Emilie Allen	4.4	9/30/2012							
4.13	Develop a collaborative process with Human Resources to monitor and develop corrective action plans for nursing staff who violate policies and procedures.	Jackie Brock John Raish	4.3	9/14/2012							
4.14	The CNO should determine approach for developing an acuity assessment methodology, e.g., internal historical record review, an automated tool, etc.	Jackie Brock John Raish	4.3	10/5/2012							

Provision of Care (POC) (Section 2.04)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
4.15	Once selected, roll out acuity tool.	Jackie Brock John Raish	4.3	3/22/2013							
4.16	Develop flexible staffing strategies, PRN pools, per diem staff, etc.	Jackie Brock John Raish	4.3	10/5/2012							
4.17	Monitor core patient care ratios for trends.	Jackie Brock John Raish	4.3	3/22/2013							
4.18	Evaluate acuity, nursing care hours annually for trends in patient care and staffing needs (electronic solution)	Jackie Brock John Raish	4.3	6/28/2013							
4.19	Establish standards of nursing practices, focusing particularly on the plan of care. (Clinical Competencies)	Barbara Mims Valerie Harvey	4.2	5/11/2012							Y
4.20	Develop house-wide nursing education program (Clinical Competencies)	Barbara Mims Valerie Harvey	4.2	8/1/2012							
4.21	Develop a house-wide competency plan that also addresses a tracking and monitoring system.	Jim Johnson	1.6	3/22/2013							
4.22	Develop tracking methodology in conjunction with Clinical Education and HR to track competencies by employee and by department.	Jim Johnson	1.6	3/22/2013							
4.23	Establish standards of nursing practices, focusing particularly on the plan of care. (Plan of Care)	Barbara Mims Valerie Harvey	4.2	5/11/2012							Y
4.24	Develop house-wide nursing education program. (Plan of Care)	Barbara Mims Valerie Harvey	4.2	8/1/2012							
4.25	Create evaluation tools to measure nurse understanding of education and success of program.	Barbara Mims Valerie Harvey	4.2	9/14/2012							
4.26	Initiate nursing ~~grand~~ clinical rounds.	Barbara Mims Valerie Harvey	4.2	7/13/2012							
4.27	Develop report out tool for grand round results.	Barbara Mims Valerie Harvey	4.2	10/1/2012							
4.28	Through the QAPI Department, develop and report verbal order trends monthly to providers and nurses.	Jackie Sullivan	6.4	9/14/2012							
4.29	Review all restraint policies.	Barbara Mims Valerie Harvey	4.2	4/20/2012							Y
4.30	Develop and execute restraint education.	Barbara Mims Valerie Harvey	4.2	6/1/2012							Y
4.31	Review Epic restraint documentation structure to improve the quality of documentation.	Barbara Mims Valerie Harvey	4.2	3/23/2012							Y
4.32	Develop a mandatory education for medical staff on the required elements of performance related to restraints.	Joseph Minei, MD	5.4	7/30/2012							
4.33	Develop a strict discipline policy that leads to termination of staff who violate the Restraint policy or a patients' rights	John Dragovits	1.5	5/25/2012							

Provision of Care (POC) (Section 2.04)

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Nursing leadership vacancy rate	Nursing		2.9%	12.6%	15.0%	13.4%		
2	Percentage of completed competencies for all nurses and units	HR							
3	Percentage of travelers	Nursing		2.1%	2.2%	2.8%	3.0%		
4	Nursing vacancy rate	Nursing		6.7%	11.5%	14.4%	16.1%		
5	Percentage of completion of education activities	Nursing	100.0%						
6	Percentage of Plan of Care documented according to policies and procedures	Nursing	100.0%	69.0%	75.0%	72.0%	67.0%		
7	Percentage of compliance in hand-off's [1]	Nursing	100.0%				75.0%		
8	Volume of non-violent restraint cases	Nursing		163	159	212	181		

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Labor productivity (staffing to include acuity)	Nursing								
2	Number of days per month nurse staffing ratios were above/below grid	Nursing								
3a	Percent of cases with verbal orders - Medications	Nursing				7.8%	8.0%	9.0%		
3b	Percent of cases with verbal orders - Procedures	Nursing				9.8%	10.0%	9.0%		
4	Percentage of staff who attended Plan of Care training	Nursing		100.0%						

Comments

4.01 - New nursing manager for these positions started 6/13. There are 8 total supervisor positions, 3 are still vacant, 1 is currently filled, and 4 have offers accepted. Being staffed by float pool. Moving to 2/shift (instead of 1) once all 8 positions are filled.
4.09 - 4.11 - Target date was extended due to change from MOSB to Lippincott
4.12 - Target date was extended due to utilization of education modules in HealthStream, which is still under contract
4.14 - 4.18 - Short term paper-based acuity solution is in development, to fully implement by end of July
4.30 - Original training was implemented, re-education in process

1. Audit results reported by Parkland Internal Audit Department. A&M has not yet validated this figure.

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Care Management (Section 2.05)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
5.01	Evaluate infrastructure and performance of the Care Management Department to include merging Utilization Management function. The evaluation of the Care Management Department will also include a review of all resources and personnel currently committed to the Care Management function to determine whether the Department has adequate resources and personnel to perform all of its required functions. The evaluation of the Care Management Department will also include a plan to merge Hospital Utilization Management functions into Care Management.	Robin Stults w/ External Resources	3.4	7/24/2012							
5.02	Re-align goals and strategy of department to promote collaboration between Case Managers, Social Work, Utilization Review and Nursing.	Robin Stults w/ External Resources	3.4	6/30/2012							Y
5.03	Develop nursing-wide education plan defining roles and responsibilities of case managers, social workers, and utilization management along with the inter-relationships between the functions.	Robin Stults w/ External Resources	3.4	6/30/2012							Y
5.04	Identify metrics needed on a daily basis to properly analyze cases.	Robin Stults w/ External Resources	3.4	6/1/2012							Y
5.05	Produce an Extended Stay High Cost Outlier Report to identify inpatients that could move to a post-acute care setting if funding permitted.	Robin Stults w/ External Resources	3.4	5/31/2012							Y
5.06	Based on evaluation of creating discharge care sites for patients without means, enter into agreements such as leasing beds in a Skilled Nursing Facility (SNF), reduced rates for Durable Medical Equipment (DME) and home oxygen, long stay hotels, etc.	Dr. Royer Jackie Stephens	3.5	7/13/2012							
5.07	Revise position expectations of the ED Case Manager .	Robin Stults w/ External Resources	3.4	6/1/2012							Y
5.08	ED Case managers should evaluate all potential admissions on whether they meet acute care criteria and assess patients' potential discharge planning needs.	Robin Stults w/ External Resources	3.4	9/30/2012							
5.09	ED case managers should perform an initial assessment on all patients being admitted to the hospital.	Robin Stults w/ External Resources	3.4	8/30/2012							
5.10	Create or revise policies and procedures that define screening, assessment and discharge planning process to identify high risk patients.	Emilie Allen	4.4	6/15/2012							Y
5.10	Educate nursing staff on proper procedure for the Discharge Planning Assessment Tool within Epic to ensure appropriate screening and referrals.	Emilie Allen	4.4	6/15/2012							
5.11	Evaluate for each Nursing Unit the best mechanisms to promote interdisciplinary communication, e.g., "brief daily huddles", rounds, EMR notations only, etc. Based on findings, pilot and implement the most effective methods.	Robin Stults w/ External Resources	3.4	9/14/2012							
5.12	Create a screening tool for case managers to include long term stay patient, avoidable days and other areas of focus.	Robin Stults w/ External Resources	3.4	7/20/2012							
5.13	Move Utilization Management within Care Management Department.	Robin Stults w/ External Resources	3.4	8/31/2012							

Care Management (Section 2.05)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Mar-12	May-12	Jun-12	Jul-12	Aug-12	Completion
5.14	The Utilization Review Plan should be re-written to include the required elements which are necessity of admission, length of stay and appropriateness of use of drugs.	Robin Stults w/ External Resources	3.4	7/24/2012							
5.15	Policies and Procedures should be revised to reflect the revised plan, and associated roles and responsibilities of staff.	Robin Stults w/ External Resources	3.4	7/30/2012							
5.16	Revise the current UR logs to ensure that all required elements are collected and formatted in order to analyze and trend type data.	Robin Stults w/ External Resources	3.4	7/31/2012							Y
5.17	Develop process to export Case Management Care Web documentation whereby the data are analyzed and trended.	Robin Stults w/ External Resources	3.4	6/30/2012							Y
5.18	Select UR metrics for tracking, monitoring, and trending. (utilize national best practices as examples for targets).	Robin Stults w/ External Resources	3.4	6/30/2012							Y
5.19	Utilize data from a comparative database that is clinically adjusted and severity adjusted to assist the Committee in identifying areas for improvement.	Robin Stults w/ External Resources	3.4	6/12/2012							Y
5.20	Analyze, trend, and summarize agreed upon data elements to the UR Committee on a regular basis. (Recommendations for actions need to be documented and reported to the Medical Executive Committee.)	Robin Stults w/ External Resources	3.4	7/31/2012							Y
5.21	~~Report unfavorable physician trends to the Patient Care Review Committee (PCRC).~~ Unexpected results will be reported to Performance Improvement (PI).	Robin Stults w/ External Resources	3.4	10/31/2012							
5.22	Monitor progress on targeted metrics and re-evaluate targeted improvement goal and/or metrics being measured.	Robin Stults w/ External Resources	3.4	7/31/2012							

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Audit Results of Number of ED Cases Intervened by CM Prior to Admission	**CM**									
2	Percentage of Case Management Intervention of 1st Day Admission.	**CM**									
3	Percentage of compliance of completion of H&P's	**CM**									

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Number of Cases with Outlier Length of Stay (LOS) (per Month)	**CM**	**1,013**			**1,028**	**928**	**1,007**			
2	Number of Avoidable Days (per Month)	**CM**	**5,184**			**5,346**	**4,852**	**4,791**			
3	Number of One-Day Stays (per Month)	**CM**	**443**			**521**	**417**	**387**			
4	30 day Readmission Trends (percent of total discharges)	**CM**	**8.7%**			**9.2%**	**9.2%**	**9.2%**			

Care Management (Section 2.05)	
Comments	
5.02 - 5.03 - Although initiatives missed their deadline, a pilot is in process with specialists to begin mid-July	Task/initiative largely on schedule for completion
5.10 - Although initiative missed its deadline, the high risk screening tool has been developed and monitoring is underway	Task/initiative may be delayed from Target Date completion
5.17 - Initiative complete, however alternative solution not developed	Task/initiative is past the Target Date deadline
Audit Results - No evidence of CM intervention prior to or during 1st day of admission	Initiative tracking not yet started

Environment of Care (EOC) (Section 2.06)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
6.01	Coordinate a multi-disciplinary team to represent the EVS department that is impacted by turnaround of beds; Nursing, ADT, EVS, ESD, House Supervision, Administration.	Kurt Dierking	3.7	4/27/2012							Y
6.02	If required, conduct a demand vs. capacity, throughput process workflow assessment and an EVS labor productivity study.	Kurt Dierking	3.7	9/14/2012							Y
6.03	If required, develop a future work flow process.	Kurt Dierking	3.7	9/14/2012							Y
6.04	Provide EVS various communication devices, hand held transmitters, pagers, cell phones, etc. to the EVS managers and EVS staff to expedite and validate the current status of the unit.	Kurt Dierking	3.7	4/11/2012							Y
6.05	Minimized delays in placing patients on unit with efficient communication and temporary deployment of additional EVS staff from other units to the unit experiencing an influx of patients.	Kurt Dierking	3.7	4/23/2012							Y
6.06	Track work orders and their respective resolutions. Analyze the issues and their resolutions to determine trends. Provide action plans for decreasing recurring issues.	Kurt Dierking	3.7	4/27/2012							Y
6.07	Create a plan for an initial cleaning "campaign" and ongoing schedule for cleaning, maintenance and incorporate monitoring.	Kurt Dierking	3.7	4/6/2012							Y
6.08	Convene the environment of care team to establish mission, charter, goals and processes to address EOC activities.	Kurt Dierking	3.7	4/6/2012							Y
6.09	Conduct a one-time, accelerated plan for deep cleaning and repairs.	Kurt Dierking	3.7	6/8/2012							Y
6.10	Develop a budget and prioritization for the "campaign" on potential staff or capital needs for senior leadership review.	Kurt Dierking	3.7	4/13/2012							Y
6.11	EVS to review existing checklists and expand where necessary for an EOC checklist for department surveillance. Issue checklists to Department Directors to ensure preparedness and awareness. Issue infraction notices to Department Director, Divisional VP and EVS Director.	Kurt Dierking	3.7	4/13/2012							Y
6.12	Conduct analysis on EVS staffing and evaluate and compare to industry benchmarks to ensure adequate resources exist to maintain the facility.	Kurt Dierking	3.7	5/11/2012							Y
6.13	Create an analysis of the current EVS process workflow to determine things such as barriers, potential improvements, productivity and performance. Develop new process flow if necessary.	Kurt Dierking	3.7	6/8/2012							Y
6.14	EOC team to submit monthly report to COO and CNO based the EOC rounds and on the action plans.	Kurt Dierking	3.7	6/8/2012							Y
6.15	Review existing scope of activities/tasks as well as frequency of cleaning schedules for each unit/space of the Hospital (and ambulatory sites) to ensure it is adequate to meet the "new" standards and/or adjustments.	Kurt Dierking	3.7	6/8/2012							Y

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Number of Charge Nurse complaints of unsatisfactory conditions per unit	EVS									
2	Percentage of Patient Rooms, Procedure Areas, and Operating Rooms, meeting all elements of EVS requirements [1]	House-Wide						85.6%			
3	Percentage of procedure areas with up to date daily terminal cleaning logs	House-Wide						87.5%			
4	Number of patient complaints about environmental issues	EVS		0	1	1	8	5			

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Bed turnaround time	EVS		1:00		1:13	1:18	1:13			
2	Work order completion time to include EVS, Facilities, and Clinical Engineering (average days)										
	EVS	EVS				13.08	0.89	0.64			
	Facilities	EVS				1.45	1.77	1.95			
	Clinical Engineering	EVS				3.38	2.52	1.91			
3	EVS labor productivity to benchmarks (paid hours/cleanable sq ft)	EVS				0.02	0.02	0.02			

Environment of Care (EOC) (Section 2.06)	
Comments	
1. Results are from A&M rounding	Task/initiative largely on schedule for completion Task/initiative may be delayed from Target Date completion Task/initiative is past the Target Date deadline Initiative tracking not yet started

Infection Control (Section 2.07)

#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
7.01	Each Divisional Vice President (VP) will submit all department specific Infection Prevention (IP) related policies and procedures to IP.	Kim McCloud Linda Licata Barbara Mims	2.8	4/20/2012							Y
7.02	The IP department Director and Chief of Infection Prevention will review and make revisions of all departmental and house-wide IP policies, if applicable.	Janet Glowicz	6.3	5/11/2012							Y
7.03	All departmental IP policies are returned to the department for their review and acceptance	Janet Glowicz	6.3	6/8/2012							Y
7.04	Approve reviewed departmental and house-wide IP policies.	Janet Glowicz	6.3	6/8/2012							
7.05	Divisional VP and Department Directors to develop a communication roll out with IP Director on the revised IP policies and procedures.	Kim McCloud Linda Licata Barbara Mims	2.8	6/8/2012							Y
7.06	Each department assigns an IP delegate to be the contact and participant in the IP prevention education program.	Kim McCloud Linda Licata Barbara Mims	2.8	6/8/2012							Y
7.07	Provide a full-time Chief Infection Prevention Officer.	Jody Springer	1.2	6/8/2012							
7.08	Survey monthly all departments for IP compliance. Survey results are sent to Department IP representative, Department Director and Divisional VP for follow up and corrective action needed and expected completion date.	Janet Glowicz	6.3	3/23/2012							Y
7.09	Execute EOC surveillance program to ensure consistency with cleaning methods and standards to support IP principles.	Janet Glowicz	6.3	3/23/2012							Y

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Percentage of policies that have been drafted/revised (by department)	**IP**	**100%**			**100%**	**98.0%**		
2	Volume of non-compliant observations for hand hygiene - Nursing Audit	**House-wide**	**0**			**1478**	**756**		
3	Compliance in hand hygiene	**House-wide**	**100%**			**96.8%**	**97.9%**		
4	Percentage of compliant observations with sterile technique in procedure areas	**Surgery**					**100%**		
5	Percentage of Infection Prevention completed surveys by each department, monthly	**IP**	**100%**				**64.7%**		

Comments

7.07 - Initiative not complete, but contract was negotiated to increase from a .5 to a .7 FTE

7.08 - Although initiative is complete, audit results reflect only 65% compliance

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Medication Management (Section 2.08)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
8.01	Conduct a medication override audit.	Vivian Johnson Dr. Shannon	2.3	6/8/2012							Y
8.02	Enhance P&T agenda with cost studies, outcomes for alternative drug options, ADR, Overrides, dosing guidelines.	Vivian Johnson Dr. Shannon	2.3	4/5/2012							Y
8.03	P&T Committee to provide report summarizing and action plans on medication analysis, ADR summaries, Narcan utilization, off label med utilization, and medication reconciliation issues to QCC.	Vivian Johnson Dr. Shannon	2.3	6/8/2012							Y
8.04	Establish baseline and develop a tool to "flag" ADRs.	Vivian Johnson Dr. Shannon	2.3	5/11/2012							Y
8.05	Trending reports based on type of reaction, location, provider, etc. and report to P&T Committee and other appropriate medical staff committees. Actions should be taken and documented on trends by the P&T Committee and reported up through the QCC Committee and Governing Board.	Vivian Johnson Dr. Shannon	2.3	6/8/2012							Y
8.06	Potential trends should be monitored with corrective action taken, e.g., ADRs identified on the same drugs, same units, same diagnoses, same physicians, etc.	Vivian Johnson Dr. Shannon	2.3	6/8/2012							Y
8.07	Explore alternatives for clinical trial identifiers.	Vivian Johnson Dr. Shannon	2.3	4/27/2012							Y
8.08	Ensure all "off label" medication use is reviewed and approved by the P&T Committee.	Vivian Johnson Dr. Shannon	2.3	4/27/2012							Y
8.09	Establish a Medication Reconciliation task force to develop a consistently compliant process.	Anne Tudhope Judy Herrington Vicki Crane	4.5	5/11/2012							Y
8.10	Conduct chart audit of medication reconciliation compliance to establish current baseline.	Anne Tudhope Judy Herrington Vicki Crane	4.5	6/15/2012							Y
8.11	Evaluate appropriateness of providing pharmacy tech support for medication reconciliation.	Vivian Johnson Dr. Shannon	2.3	5/11/2012							Y
8.12	Develop and provide education for pilot study for the participating Pharmacy Techs and RNs.	Vivian Johnson Dr. Shannon	2.3	6/8/2012							Y
8.13	Conduct pilot study. Collect and present results.	Vivian Johnson Dr. Shannon	2.3	6/8/2012							Y

Medication Management (Section 2.08)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
8.14	Develop future state work flow processes.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.15	Pilot the new work flow process.	Vivian Johnson Dr. Shannon	2.3	7/13/2012	●	●	●	●			
8.16	Implement new reconciliation process (in EPIC).	Anne Tudhope Judy Herrington Vicki Crane	4.5	9/14/2012	●	●	●	●			
8.17	Reassign the crash cart management under the Sterile Processing Department and/or Pharmacy.	Anne Tudhope Judy Herrington Vicki Crane	4.5	4/13/2012	●	●	●	●			Y
8.18	Assess the space requirements and human resources needed for case cart management within SPD.	Anne Tudhope Judy Herrington Vicki Crane	4.5	7/16/2012	●	●	●	●			Y
8.19	Revisit the cart management processes for supplies and pharmaceuticals.	Anne Tudhope Judy Herrington Vicki Crane	4.5	5/11/2012	●	●	●	●			Y
8.20	Ensure the supply and pharmaceutical lists match the components in the carts and validate the accuracy of lists and components with Pharmacy and Nursing Education.	Anne Tudhope Judy Herrington Vicki Crane	4.5	3/22/2013	●	●	●	●			Y
8.21	Implement an accountability process and sign off process to ensure accuracy and products are not expired.	Anne Tudhope Judy Herrington Vicki Crane	4.5	8/13/2012	●	●	●	●			
8.22	Conduct cart initial audit for validation after transferring case cart management to SPD.	Anne Tudhope Judy Herrington Vicki Crane	4.5	8/13/2012	●	●	●	●			

Medication Management (Section 2.08)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	3/1/2012	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
8.23	Present drug storage audit and data collection program.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.24	Pharmacy Resources and Nurse Liaisons (Charge Nurse) are assigned for each unit.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.25	Pharmacy & Unit-Based Nursing Resources conduct audits (Nursing - part of daily checklist for eight weeks); Pharmacy (monthly as a part of trending & monitoring)	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.26	Nursing Liaison collects, collates and summarizes audit results and submits on the data tool to the Pharmacy Resource weekly.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.27	Pharmacy Resource analyzes data from Nurse Liaison reports and provides monthly summary interim reports to Nurse Liaison, Unit Manager and Department Director.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.28	Pharmacy Resource collects collates and summarizes audit results and submits monthly audit on the data tool.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.29	Establish a multi-disciplinary RCI Medication Safety Team.	Vivian Johnson Dr. Shannon	2.3	4/13/2012	●	●	●	●			Y
8.30	Investigate the root causes of the medication errors and categorize the errors and provide tactical plans towards resolution.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.31	Review the medication ordering, preparation and administration process through a work flow process.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.32	Revise medication administration process based on finding of work flow analysis.	Vivian Johnson Dr. Shannon	2.3	6/8/2012	●	●	●	●			Y
8.33	Provide the education plan base on the work flow model findings that address the gaps in the safe delivery of medications.	Vivian Johnson Dr. Shannon	2.3	9/14/2012	●	●	●	●			
8.34	Develop core competence education program for all the clinical staff in regards to the practices of safe medication delivery. This module should be included in the staff's annual competency evaluation.	Vivian Johnson Dr. Shannon	2.3	9/14/2012	●	●	●	●			
8.35	In conjunction with current internal hospital initiatives, define those care settings that moderate sedation is required versus pain management.	Anne Tudhope Judy Herrington Vicki Crane	4.5	8/13/2012	●	●	●	●			Y

Medication Management (Section 2.08)

#	Tasks/Initiatives	Accountability	Work Stream	Target Date	3/1/2012	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
8.36	Ensure all clinicians are qualified to administer medications that have the clinical effect of moderate sedation.	Anne Tudhope Judy Herrington Vicki Crane	4.5	8/13/2012	🟡	🟡	🟢	🟢			Y
8.37	Ensure compliance with new moderate sedation practice standards.	Anne Tudhope Judy Herrington Vicki Crane	4.5	8/13/2012	🟡	🟡	🟢	🟢			
8.38	Review the medications in Pyxis on the IP units that have access to "moderate sedation categorized" medications to determine how they should be "flagged" for monitoring.	Anne Tudhope Judy Herrington Vicki Crane	4.5	8/13/2012	🟢	🟢	🟢	🟢			
8.39	Conduct an audit on the daily Pyxis report (Epic Clarity Report) on Narcan use in patients undergoing pain management and moderate sedation in non-procedure based units.	Vivian Johnson Dr. Shannon	2.3	3/22/2013	⚫	🟢	🟢	🟢			Y

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	MD Max Overrides reviewed by RPH	**Pharmacy**	**100%**		**100%**	**100%**	**100%**		
2	Percentage of completed medication reconciliations per audit [1]	**House-Wide**					**68.6%**		
3	Percentage of locations with unsecured medications	**Pharmacy**	**0%**			**2.0%**	**1.7%**		
4	Percentage of compliant crash carts	**SPD**				**99.3%**	**100.0%**		
5	Number of improper or lack of medication labeling	**Pharmacy**					**121**		

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Percentage of off label medication reviewed by P&T Committee	**Pharmacy**	**0%**	**100%**			**51%**	**100%**		
2	Number of adverse drug reactions [2]	**Pharmacy**	**19**	**31**	**26**	**21**	**194**	**126**		
3	Missed medications	**Pharmacy**	**11.4%**		**12.0%**	**14.0%**	**10.0%**	**12.0%**		
4	Time from physician medication order to first dose by unit	**Pharmacy**								
5	Number of opiod induced respiratory depressions naloxone administration	**Pharmacy**		**0**		**4**	**7**	**8**		

Comments

8.16 - Target date extended, originally due in June, to implement new process across all systems and provide education

1. Audit result is self reported. A&M has not yet validated this figure.
2. Methodology to track and collect adverse drug reactions changed in May, 2012

🟢 Task/initiative largely on schedule for completion
🟡 Task/initiative may be delayed from Target Date completion
🔴 Task/initiative is past the Target Date deadline
⚫ Initiative tracking not yet started

Patient Safety/Rights (Section 2.09)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
9.01	Create job description for new Chief Patient Rights and Safety Officer (CPRSO).	Jody Springer	1.2	3/30/2012							Y
~~9.02~~	~~Name Interim Chief Patient Rights and Safety Officer (CPRSO)~~	~~Jody Springer~~	~~1.2~~	~~4/6/2012~~							
9.03	National search to recruit new Chief Patient Rights and Safety Officer (CPRSO)	Jody Springer	1.2	5/11/2012							
9.04	The following quality and safety functions at Parkland would be reorganized to report directly to the CPRSO: Patient Safety Patient Safety Investigations Root Cause Analysis (RCA) Patient Safety Incident Reporting PSN Database Maintenance and Reporting State, Federal and Joint Commission Reporting "Continual Readiness"/CMS, State and Joint Commission Survey Preparation "Daily Rounding" Function Infection Prevention and Control · Patient Relations (Patient complaints and grievances, which currently reports to Nursing)	Jody Springer	1.2	5/11/2012							
9.05	New job descriptions for all employees and managers, supervisors and department heads in units and divisions now reporting to the CPRSO.	Jody Springer	1.2	5/11/2012							
9.06	Review and redesign of all patient rights and safety related policies and procedures.	Lisa Betterson	6.2	6/8/2012							
9.07	Develop education plan for all employees regarding patient safety and rights policy/procedure changes.	Lisa Betterson	6.2	8/15/2012							
9.08	Reorganize and redesign its Quality Department and its centralized Quality Assessment/Performance Improvement (QAPI) functions to include: Clinical Data Management Performance Improvement Rapid Cycle Improvement	Jackie Sullivan	6.1	6/8/2012							Y
9.09	Create new Human Resources policy on violations of Patient Rights/Patient Safety obligations.	John Dragovits	1.5	6/8/2012							
9.10	Create a Patient Rights/Patient Safety Awareness Campaign.	Lisa Betterson	6.2	4/27/2012							Y
9.11	Create a "Safe Patient Hand offs"/Continuity of Patient Care Awareness Campaign	Lisa Betterson	6.2	5/11/2012							Y
9.12	New education and training for current and new employees and physicians on safe patient handoffs and continuity of patient care.	Lisa Betterson	6.2	8/15/2012							
9.13	Parkland should conduct a study to look at best practices of other large hospital police departments to compare the level of specialized training provided to Parkland Police Department against other hospital police departments. Best practice for reporting structure should also be investigated.	Jody Springer	1.2	4/13/2012							Y
9.14	Patient Rights and Safety Department Study and Task Force (to include Nursing, Police, Patient Safety, and Patient Relations representatives) on Elopements and Patients leaving.	Lisa Betterson	6.2	6/1/2012							Y
9.15	Work with Parkland Police Department and Nursing the Patient Rights and Safety Department should conduct a study of all documented elopements in 2011 and determine reasons for elopement (e.g., breeches in security, caregiver training, etc.) and provide action plan and recommendations for reducing elopements.	Lisa Betterson	6.2	3/30/2012							Y
9.16	Patient Rights and Safety Department should then begin to conduct chart reviews for all patients who elope or leave AMA. The review should separately categorize all departments, including a separate review for elopements and patients leaving AMA in the Emergency Department. The chart review should then develop a list of reasons as to why patients leave elope or leave AMA, and subsequent reports should trend in these categories.	Lisa Betterson	6.2	3/22/2013							Y

Patient Safety/Rights (Section 2.09)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
9.17	Complete current RCI initiative regarding 1:1 observation procedure and competencies required for staff.	Lisa Betterson	6.2	6/1/2012							Y
9.18	Evaluate additional CM staff to ED.	Robin Stults w/ External Resources	3.4	7/31/2012							Y
9.19	Establish a documentation committee, led by HIM, that includes Clinical support from Chief Nursing Officer and Chief Medical Officer, Support Services, ADT, Legal, Patient Safety, Performance Improvement and HIM representation to address the inconsistencies of properly executed documents, lack of complete and accurate documentation, and lack of compliance.	Lisa Betterson	6.2	9/14/2012							Y
9.20	Develop and implement an action plan that addresses non-compliance and the steps to the solution.	Lisa Betterson	6.2	9/14/2012							
9.21	Review all policies and procedures related to the areas of non-compliance to determine and ensure policies are updated to current regulations or standards of practice.	Lisa Betterson	6.2	9/14/2012							
9.22	Determine where and if the resources are available or needed to meet the documentation requirements.	Lisa Betterson	6.2	9/14/2012							
9.23	HIM shall conduct routine chart audits to document that all patients have been provided with: 1) required information on their rights under Medicare, federal law and state law; 2) required information on advance directives. Chart audits shall also assess whether all Medicare patients are receiving the notice entitled: "Important Message from Medicare."	Lisa Betterson	6.2	9/14/2012							
9.24	Review Hospital policy for Patient Grievance procedure and compare to best practice, including those noted above.	Lisa Betterson	6.2	5/25/2012							Y
9.25	Develop monitoring system to ensure timelines required by Hospital policy are met.	Lisa Betterson	6.2	6/8/2012							
9.26	Patient Relations Department should create a new monthly reporting system for all patient grievances and complaints. The reporting system should show, at a minimum: number of complaints/grievances received; actionable categories for all complaints/grievances (some complaints/grievances may fall in several categories); person making complaint (patient, family member, staff, physician, etc.); time between receipt of complaint and response to patients; documentation that patient agreed/disagreed that compliant/grievance was resolved; inventory of complaint/grievance by department/unit/floor and confidentiality by employee and physician; trending of grievances/complaints over months/years in all above categories.	Lisa Betterson	6.2	9/14/2012							
9.27	Develop and implement a Privacy task force to identify areas of non-compliance (including HIPAA), indicators to measure, and to develop an awareness campaign.	Lisa Betterson	6.2	6/8/2012							Y
9.28	Conduct Patient Privacy Awareness Campaign to reacquaint staff on HIPAA and other privacy obligations. Privacy Awareness campaign should include examples of recent privacy breaches.	Lisa Betterson	6.2	9/14/2012							Y
9.29	Review current privacy training materials. Require annual competency on HIPAA and other patient rights but revise competency annually to refresh materials and learning behaviors for better retention of information.	Lisa Betterson	6.2	9/14/2012							
9.30	Utilize tool developed by Executive VP of Operations or another developed tool to conduct weekly customer relations tours.	Lisa Betterson	6.2	7/1/2012							
9.31	Develop a dashboard and track and trend the indicators for Patient Rights and the progress to the target thresholds.	Lisa Betterson	6.2	9/14/2012							

Patient Safety/Rights (Section 2.09)

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Percentage of policies and procedures reviewed and/or revised.	Pat Safety	100%			20.69%	44.40%		
2	Percentage of staff provided education on patient rights and patient safety	Pat Safety	100%						
3	Percentage of staff provided education on safe patient hand offs	Nursing	100%						
4	Attendance for state mandated training courses for members of Police Department	Police				83.30%	100.00%		
5	Average time from event to completion of patient safety investigation (days)	Pat Safety	10	6.88	10.73	15.02	15.36		
6	Number of regulatory reports that exceed the time to report based on policy or regulations	Perf Imp							
7	Number of patient complaints and grievances	Pat Griev		390	328	442	584		
8	Average time from event to resolution of patient complaint or grievance	Pat Griev		14	16.5	13	19.5		
9	Percentage of patients who did not receive appropriate notifications (under applicable Medicare, state and other laws, "Important Message from Medicare", others), as audited by HIM	HIM							

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of Patient Safety Investigations	Pat Safety			27	39	50	46		
2	Number of elopements, AWOLS, AMA (excluding ED)	Pat Safety	59		59	61	56	64		

Comments

9.06 - Initiate in process, most policies currently sitting with Legal department
9.07 - Initiative delayed due to large volume of training to achieve 90% attendance rate
9.14 - Although Task Force has addressed this issue, volume of elopements continues to rise
9.25 - Initiative missed deadline due to long contracting timeframe with external data provider
9.30 - Executive rounding has not begun

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Medical Staff (Section 2.10)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
10.01	Develop an OPPE/FPPE review template for each medical department and/or service.	Patricia Bergen, MD	5.1	4/20/2012							Y
10.02	Develop a written procedure explaining the OPPE process, criteria and physician referral process for FPPE.	Patricia Bergen, MD	5.1	4/20/2012							
10.03	Define required physician profile elements for all physicians.	Patricia Bergen, MD	5.1	4/20/2012							Y
10.04	Provide all department chairs the required template, guidance, and a timeline for completion of departmental criteria, indicators, and thresholds of performance.	Patricia Bergen, MD	5.1	1/31/2013							
10.05	Review and "sign off" of CMO and QAPI of the departmental ~~OPPE plans~~ Professional Staff Quality Management Plan for relevance and compliance.	Patricia Bergen, MD	5.1	7/30/2012							
10.06	Review and obtain approval of OPPE/FPPE process and criteria by MEC, and then the Governing Board.	Patricia Bergen, MD	5.1	7/13/2012							
10.07	Each department should develop a standard set of metrics for use on cases sent for peer review.	Patricia Bergen, MD	5.1	7/1/2012							
10.08	~~Medical Staff Office~~ Quality Department to establish a methodology to track and trend all cases brought to peer review	Patricia Bergen, MD	5.1	6/8/2012							
10.09	~~Patient Safety~~ PCRC to revise and standardize scoring system used to refer cases to peer review.	Patricia Bergen, MD	5.1	8/31/2012							
10.10	Determine necessity to expand Medical Staff resources.	Patricia Bergen, MD	5.1	7/13/2012							
10.11	Charter a joint Hospital/GME Faculty Task Force. Create a venue for collaboration and discussion of issues between Hospital and Faculty to inform and appraise between residency update periods. Members to include Hospital VPs and Faculty Medical Staff.	Brad Marple, MD	5.3	4/27/2012							Y
10.12	Develop an audit and reporting method for compliance with the ACGME 2012 Common Program Requirements that will require each departmental residency program to specify the types of patient events that will require a Resident to call the teaching physician. Use the audit to develop an operational report to concurrently manage the Residents during the academic year.	Brad Marple, MD	5.3	7/30/2012							
10.13	Develop a training module enabling faculty to instruct residents when to escalate issues to their Attending Physicians.	Brad Marple, MD	5.3	7/30/2012							
10.14	Standardize use of Innovations (resident management software) across the system to create a web-enabled database of individual resident certification profile; (presently nurse can access the department grid, see what a PGY-2 is qualified to do, and then look up the name of a particular PGY2 and determine whether he/she is certified to it.	Brad Marple, MD	5.3	6/15/2012							
10.14a	Interim option for access to resident qualifications	Brad Marple, MD	5.3	7/30/2012							
10.15	Modify Grid to highlight those events or add link to the list of and procedures that require concurrent notification of the attending physician that is available to all departments.	Brad Marple, MD	5.3	7/30/2012							
10.16	Review Grid or list to ensure that it includes the list of all events that require escalation notification to an Attending (i.e., lower the reporting threshold).	Brad Marple, MD	5.3	7/30/2012							
10.17	Create policy contingencies for alternate modes of supervision or escalation, i.e., what to do when the expected senior resident or Teaching Physician is not accessible in the expected time period.	Brad Marple, MD	5.3	5/11/2012							

Medical Staff (Section 2.10)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
10.18	Evaluate Parkland's Epic functionality, to determine improvement to be made in documentation or note entry to provide consistent and reliable documentation of Attending Physician oversight, approval and concurrence with Resident orders.	Brad Marple, MD	5.3	7/30/2012	🟢	🟡	🟡	🟡			
10.19	Evaluate Parkland's call system ability to properly attribute the Resident and Attending Physician to each patient. Create an audit tool for weekly confirmation that call system is accurately and timely attributing Residents and Attending Physicians to each patient.	Joseph Minei, MD	5.4	6/8/2012	⚫	🟡	🟢	🔴			
10.20	Upgrade Epic with user capability to concurrently update treatment teams through use of the physician order entry function.	Joseph Minei, MD	5.4	7/1/2012	🟡	🟡	🟡	🟡			
10.21	Standardize call schedule procedure for consulting services.	Joseph Minei, MD	5.4	4/27/2012	🟡	🔴	🔴	🔴			
10.22	Ensure the accuracy Amcom scheduling system (source of truth maintained by Parkland)	Joseph Minei, MD	5.4	7/15/2012	🟢	🟡	🔴	🟡			
~~**10.23**~~	~~Create contingencies for alternate modes of supervision or escalation.~~	~~Joseph Minei, MD~~	~~5.4~~	~~5/11/2012~~							
10.24	Parkland's GME Director should review the current training and education materials for Residents on documentation, particularly documentation of H&Ps.	Brad Marple, MD	5.3	5/11/2012	🟡	🟢	🟢	🟢			Y
10.25	Refresher education and training should be conducted for all Residents.	Brad Marple, MD	5.3	7/30/2012	🟡	🟡	🟡	🟡			
10.26	Perform audit of Residents' History and Physicals (H&P) documentation for completion and adherence to Parkland policy and procedures.	Brad Marple, MD	5.3	3/22/2013	⚫	⚫	⚫	🟢			

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of referrals to peer review	**Med Staff**		**178**	**47**	**23**	**40**		
2	Percentage of Medical Staff with OPPE Data at conclusion of next eight-month cycle	**Perf Imp**							
3	Call System accuracy [1]	**House-Wide**				**61%**	**N/A**		

Comments

10.02 - Awaiting approval by PCRC, Credentialing Committee, and the Medical Executive Committee (MEC)

10.04 - Initiative complete for 5 pilot departments, progressing toward target date toward implementing house-wide

10.12 - Electronic solution has been developed, realized challenges in one department - ED

10.18 - Work continues within IT to automate progress notes within Epic. Audits indicate this is a problem area. Physician group is targeting July for completion.

1. Rounding ceased in June due to call system process changes

🟢 Task/initiative largely on schedule for completion

🟡 Task/initiative may be delayed from Target Date completion

🔴 Task/initiative is past the Target Date deadline

⚫ Initiative tracking not yet started

Emergency Services (Section 2.11)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
11.01	Conduct a quantitative demand and process analyses of the ESD in order to properly balance work flow, capacitate the various components of the split flow system, and accurately determine any changes in bed capacity, service hours or staffing.	Clifann McCarley	3.2	4/27/2012							Y
11.02	Throughput and productivity assessment of the "current state" in the form of a process work flow diagram including the following elements: inputs, activity steps, decision points, enablers, functions and outputs	Clifann McCarley	3.2	4/27/2012							Y
11.03	Identify rate limiting factors such as lack of equipment/technology, availability and/or staffing within budget guidelines, and hours of operations.	Clifann McCarley	3.2	4/27/2012							Y
11.04	Server cycle times need to be measured and applied to the design of care teams in the Triage and the Intake areas.	Clifann McCarley	3.2	4/27/2012							Y
11.05	Conduct a benchmarking study of its Emergency Department labor productivity to industry standards in order to determine if there are opportunities to improve productivity and thereby increase capacity for each service area.	Clifann McCarley	3.2	7/13/2012							Y
11.06	Redesign of the future process flow to eliminate waste, such as: removing or combining steps, automating any manual activity steps, if possible, transferring elements to other departments, changing the location where the steps are done, and finally altering/modify the activity step	Clifann McCarley	3.2	6/8/2012							Y
11.07	Work flow models should be piloted with Rapid Cycle Testing and refined as necessary and then training provided	Clifann McCarley	3.2	7/13/2012							
11.08	Periodic reviews of process work flow using Plan-Do-Check-Adjust (PDCA) Lean techniques.	Clifann McCarley	3.2	9/14/2012							
11.09	Change functionality in Epic to reflect changes in work flow processes and new treatment areas.	Clifann McCarley	3.2	6/8/2012							Y
11.10	Recruitment, credentialing and on-boarding of qualified physicians.	Patricia Bergen, MD	5.1	6/8/2012							Y
11.11	Pathology to scope operations, licensing, certification requirements for Point of Care labs.	Deb Perrault	2.2	5/11/2012							Y
11.12	Develop signage text consistent with the educational level and primary languages of the population served that is consistent across the institution.	Clifann McCarley	3.2	5/11/2012							Y
11.13	List all sites and specific rooms requiring posting of signage	Clifann McCarley	3.2	5/11/2012							Y
11.14	Obtain approval of final language for signage	Clifann McCarley	3.2	5/25/2012							Y
11.15	Physical Plant and Facilities to arrange for printing and posting final approved signs.	Clifann McCarley	3.2	6/8/2012							Y
11.16	Post new signage	Clifann McCarley	3.2	7/13/2012							
11.17	Review and revise all EMTALA related Policy and Procedures.	Clifann McCarley	3.2	6/8/2012							Y
11.18	Create/Revise training materials for new EMTALA Policy and Procedures	Clifann McCarley	3.2	7/13/2012							

Emergency Services (Section 2.11)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
11.19	Re-educate on new EMTALA Policy and Procedures.	Clifann McCarley	3.2	3/22/2013							
11.20	Annual review ESD Nurses, Physicians and other Caregivers and Staff.	Emilie Allen	4.4	5/20/2013							
11.21	Re-educate staff on new patient registration policies on Emergency Registration Process	Emilie Allen	4.4	6/8/2012							Y
11.22	Develop and finalize a survey technique.	Clifann McCarley	3.2	5/12/2013							
11.23	Develop a patient flow process to eliminate disparate treatment in evaluation and delay in the care of a person presenting to the ESD seeking Psychiatric emergency care.	Clifann McCarley	3.2	9/14/2012							
11.24	Review and revise all Hand-Off related Policy and Procedures.	Barbara Mims Valerie Harvey	4.2	5/25/2012							Y
11.25	Create/Revise training materials for new Hand-Off Policy and Procedures.	Barbara Mims Valerie Harvey	4.2	7/13/2012							Y
11.26	Re-educate on new Hand-Off Policy and Procedures.	Barbara Mims Valerie Harvey	4.2	8/15/2012							
11.27	Work with IT/Epic to develop access to information required by law.	Clifann McCarley	3.2	6/8/2012							Y
11.28	Develop reporting function with Epic for output of Central Log Reports.	Clifann McCarley	3.2	6/8/2012							Y
11.29	Create training materials for accessing information required by law and reporting functions through Epic.	Clifann McCarley	3.2	7/13/2012							Y
11.30	Re-educate staff on accessing information required by law and reporting functions through Epic.	Clifann McCarley	3.2	9/14/2012							Y
11.31	Monitor and audit compliance to determine if management can generate a central patient log.	Clifann McCarley	3.2	9/14/2012							
11.32	Review and revise policy and procedures on receiving hospital transfer requirements.	Clifann McCarley	3.2	4/13/2012							Y
11.33	Create/Revise training materials for new policy and procedures.	Clifann McCarley	3.2	4/27/2012							Y
11.34	Re-educate on new policy and procedures.	Clifann McCarley	3.2	5/18/2012							Y
11.35	Annual review ESD Nurses, Physicians and other Caregivers and Staff.	Emilie Allen	4.4	5/12/2013							

Emergency Services (Section 2.11)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
11.36	Review and revise policy and procedures on Memorandum of Transfer requirements.	Clifann McCarley	3.2	4/13/2012							Y
11.37	Create/Revise training materials for new policy and procedures.	Clifann McCarley	3.2	4/27/2012							Y
11.38	Re-educate on new policy and procedures.	Clifann McCarley	3.2	5/18/2012							Y
11.39	Annual review ESD Nurses, Physicians and other Caregivers and Staff.	Emilie Allen	4.4	5/12/2013							
11.40	Review and revise policy and procedures on nursing assessment and plan of care requirements.	Emilie Allen	4.4	9/9/2012							
11.41	Create/Revise training materials for new policy and procedures.	Emilie Allen	4.4	9/9/2012							
11.42	Re-educate on new policy and procedures.	Emilie Allen	4.4	9/9/2012							
11.43	Annual review ESD Nurses, Physicians and other Caregivers and Staff.	Emilie Allen	4.4	5/18/2013							
11.44	The Emergency Services Director of Nursing should determine approach for developing an acuity assessment methodology, e.g., internal historical record review, an automated tool, etc.	Jackie Brock John Raish	4.3	10/5/2012							
11.45	Once selected, roll out acuity tool.	Jackie Brock John Raish	4.3	3/22/2013							
11.46	Develop flexible staffing strategies, PRN pools, per diem staff, etc.	Jackie Brock John Raish	4.3	3/22/2013							Y
11.47	Monitor core patient care ratios for trends.	Jackie Brock John Raish	4.3	3/22/2013							Y
11.48	Evaluate acuity, nursing care hours annually for trends in patient care and staffing needs.	Jackie Brock John Raish	4.3	6/28/2013							

Emergency Services (Section 2.11)										
#	Audit/Measures	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
	Main ED									
1	Total number of hours of ED boarding	ESD					3135	2829		
2	Average number of patients in ED that are boarding per day	ESD					47	45		
3	Average "Compassionate" dialysis patients transferred from ED/day	ESD					15	14		
4	Turnaround time to discharge patients to home (door to home, in minutes)	ESD			430	334	338	313		
5	Door to seen by 1st Provider (minutes)	ESD	92		124	112	109	99		
6	Number of ED admits that should have been direct admits	ESD								
7	Hours on resource alert	ESD					360	334		
8	Door to Room Time (minutes)	ESD	93		140	175	163	172		
9	Left without being seen	ESD				8.7%	8.8%	6.0%		
10	Left without being treated	ESD				2.0%	2.1%	2.3%		
11	Percentage of patients admitted	ESD					27.7%	25.6%		
12	Percentage of patients discharged	ESD					63.3%	65.8%		
13	Average ED throughput time - time from patient arrival to patient disposition (all EDs)	ESD					396.17	363.95		
	Urgent Care Clinic (UCC)									
14	Turnaround time to discharge patients to home (door to home, in minutes)	ESD					222	240		
15	Door to seen by 1st Provider (minutes)	ESD	107		69	62	64	63		
16	Number of ED admits that should have been direct admits	ESD								
17	Door to Room Time (minutes)	ESD	264		260	231	193	247		
18	Left without being seen	ESD				11.6%	9.1%	10.6%		
19	Left without being treated	ESD				0.9%	1.1%	0.9%		
20	Percentage of patients admitted	ESD					0.0%	0.0%		
21	Percentage of patients discharged	ESD					91.5%	91.9%		
22	Average ED throughput time - time from patient arrival to patient disposition (all EDs)	ESD					245.32	258.40		
	OB Gyn Intensive Care Clinic (ICC)									
23	Total number of hours of ED boarding	WISH					106	120		
24	Average number of patients in ED that are boarding per day	WISH					2.0	1.9		
25	Turnaround time to discharge patients to home (door to home, in minutes)	WISH					313	385		
26	Door to seen by 1st Provider (minutes)	WISH	126		153	195	180	198		
27	Number of ED admits that should have been direct admits	WISH								
28	Hours on resource alert	WISH			0	6	0	0		
29	Door to Room Time (minutes)	WISH	107		140	175	163	172		
30	Left without being seen	WISH				5.8%	2.9%	4.1%		
31	Left without being treated	WISH				8.3%	8.9%	14.9%		
32	Percentage of patients admitted	WISH					10.1%	10.2%		
33	Percentage of patients discharged	WISH					73.0%	66.9%		
34	Average ED throughput time - time from patient arrival to patient disposition (all EDs)	ESD					359.14	446.35		

Emergency Services (Section 2.11)										
#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Labor Productivity (staffing to include acuity)	ESD								
2	Percentage of travelers - ED	ESD			15.1%	17.9%	20.8%	20.9%		

Comments	
	Task/initiative largely on schedule for completion
	Task/initiative may be delayed from Target Date completion
	Task/initiative is past the Target Date deadline
	Initiative tracking not yet started

Psychiatry Services (Section 2.12)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
12.01	Develop clear "vision" of a psychiatric services (with particularly focus on PED) care delivery model.	Olga Rodriguez	2.1	4/27/2012							Y
12.02	Hire interim management for Psychiatric Director and psychiatric experienced/trained Nursing Manager for PED.	Jody Springer	1.2	4/27/2012							
12.03	Commence national search for permanent Director of Psychiatric Services.	Jody Springer	1.2	6/8/2012							
12.04	Develop a detailed implementation plan (based on this corrective action plan) led by the psychiatric management team. Define a management scorecard that can be utilized.	Olga Rodriguez	2.1	5/14/2012							Y
12.05	Create by discipline specific roles and responsibilities in alignment with new care delivery model.	Olga Rodriguez	2.1	6/22/2012							Y
12.06	Create new competencies and education models.	Emilie Allen	4.4	5/25/2012							Y
12.07	Create permanent staffing grids for PED and 8 North based upon census and acuity.	Jackie Brock John Raish	4.3	7/31/2012							
12.08	Further develop the charge nurse role in the PED and on 8 North.	Jackie Brock John Raish	4.3	7/31/2012							
12.09	Develop, test, and validate acuity methodologies for PED and 8 North.	Jackie Brock John Raish	4.3	7/31/2012							
12.10	Validate Social Workers coverage and effectiveness.	Olga Rodriguez	2.1	4/13/2012							Y
12.11	Implement short term strategy for consistent physician coverage.	Jody Springer	1.2	9/14/2012							
12.12	Continue recruitment efforts aggressively to fill permanent positions.	Jody Springer	1.2	6/8/2012							
12.13	Identify staff knowledge gaps.	Emilie Allen	4.4	6/8/2012							Y
12.14	Utilize psychiatric–trained resources for competency development and training.	Emilie Allen	4.4	6/1/2012							Y
12.15	Develop comprehensive PED education plan.	Olga Rodriguez	2.1	6/8/2012							Y
12.16	Incorporate required physician competencies into OPPE/FPPE.	Patricia Bergen, MD	5.1	6/8/2012							Y
12.17	Implement a discharge huddle with the MD, nursing staff, social worker, and a designated facilitator.	Olga Rodriguez	2.1	5/1/2012							Y
12.18	Develop interdisciplinary communication and planning for the plan of care.	Olga Rodriguez	2.1	8/1/2012							
12.19	Develop suicide risk and behavioral quadrant assessment tools.	Olga Rodriguez	2.1	6/8/2012							Y

Psychiatry Services (Section 2.12)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
12.20	Conduct a pilot on the suicide risk and behavioral quadrant assessment tools.	Olga Rodriguez	2.1	6/29/2012							
12.21	Educate team members on the purpose and the usability of the tool and how it's integrated into the plan of care.	Olga Rodriguez	2.1	7/13/2012							
12.22	Develop cross-functional Parkland behavioral health team.	Dr. Royer Jackie Stephens	3.5	7/13/2012							
12.23	Analyze the patient population served by all of Parkland behavioral health disciplines.	Dr. Royer Jackie Stephens	3.5	9/14/2012							
12.24	Work with DBHLT on reducing or eliminating identified gaps in care across the continuum of care in Dallas County.	Dr. Royer Jackie Stephens	3.5	9/14/2012							
12.25	Continue redesign planning of day room and back entrance for better space utilization.	Olga Rodriguez	2.1	6/8/2012							Y
12.26	Initiate multi-disciplinary team to consider PED space redesign.	Olga Rodriguez	2.1	6/8/2012							Y
12.27	Develop alternative workflows for continued PED patient care during physical space construction/redesign.	Olga Rodriguez	2.1	6/8/2012							Y
12.28	Develop budget for recommended physical changes.	Olga Rodriguez	2.1	6/8/2012							Y
12.29	Develop alternative safety alerts for day room restroom.	Olga Rodriguez	2.1	4/20/2012							Y

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Audit Results of Number of PED Cases Intervened by CM Prior to Admission	**PED/CM**				**94.00%**	**100.00%**		
2	Percentage of patients seen by social workers (8N and PED)	**Pysch**			**98.90%**	**98.20%**	**97.38%**		
3	Hours on resource alert	**PED**		**104**	**0**	**532**	**672**		
4	Percentage of patients with a documented discharge huddle	**Psych**			**97.90%**	**100.00%**	**100.00%**		
5	Percentage of patients admitted	**Psych**			**28%**	**29%**	**31%**		
6	Percentage of patients discharged	**Psych**			**71%**	**68%**	**67%**		
7	Turnaround time to discharge patients to home (door to home)	**PED**		**609.11**	**698.27**	**648.30**	**682.49**		
8	Door to seen by 1st Provider (minutes)	**PED**		**128**	**143**	**139**	**182**		
9	Door to Room Time (minutes)	**PED**		**60**	**33**	**45**	**46**		

Psychiatry Services (Section 2.12)										
#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Labor productivity (staffing to include acuity)	Psych								
2	Percentage of restraint cases	Psych								
a	Violent	Psych	4.2%		2.5%	1.8%	3.1%	1.7%		
b	Non-violent	Psych								
3	Volume of non violent restraint episodes	Psych			163	159	212	181		
3	Percentage of seclusion cases	Psych					1.19%	1.08%		
4	Number of patients with scheduled appointments at discharge	Psych								
5	Percentage of travelers - Psych	Psych			21.4%	17.2%	18.8%	26.9%		
6	Total PED throughput time - time from patient arrival to patient disposition	PED				554.25	555.00	564.00		

Comments	
12.02 - 12.03 - Need to relaunch search for Director of Psychiatric Services	Task/initiative largely on schedule for completion
12.07 - 12.09 - Missed target date to ensure design of staffing grids is appropriate	Task/initiative may be delayed from Target Date completion
12.20 - 12.21 - Initiative in process. Acquiring best practices, initiative is more thorough and detailed causing delay	Task/initiative is past the Target Date deadline
	Initiative tracking not yet started

Women and Infant's Specialty Health (WISH) (Section 2.13)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
13.01	Ensure plan of care practices are standardized and followed regularly.	Barbara Mims Valerie Harvey	4.2	3/22/2013							
13.02	Standardize hand off procedures. Educate staff.	Barbara Mims Valerie Harvey	4.2	8/15/2012							
13.03	Begin recruitment of key leadership positions – Nursing Director (L&D) and Nursing Manager (L&D).	Jackie Brock John Raish	4.3	6/8/2012							Y
13.04	Evaluate job description and determine best solution to work load balance for Nurse Manager (Postpartum).	Jackie Brock John Raish	4.3	4/13/2012							Y
13.05	Begin recruitment of additional Nurse Manager candidates (Postpartum).	Jackie Brock John Raish	4.3	5/11/2012							Y
13.06	Evaluate job descriptions of Nurse Managers to determine if additional administrative support is required.	Paula Turicchi	2.4	7/15/2012							
13.07	Begin recruitment for administrative support roles (if appropriate).	Paula Turicchi	2.4	7/22/2012							
13.08	Recruit, hire and train additional staff to fill vacancies.	Jackie Brock John Raish	4.3	6/8/2012							Y
13.09	Evaluate nurse staffing needs based upon any plans for increase in capacity.	Jackie Brock John Raish	4.3	4/27/2012							Y
13.10	Recruit, hire and train additional staff as required.	Jackie Brock John Raish	4.3	6/8/2012							Y
13.11	Re-design staffing model to include adjustment for acuity.	Jackie Brock John Raish	4.3	6/8/2012							Y
13.12	Evaluate job descriptions for inclusion of appropriate competencies and to ensure duties assigned are within scope of practice.	Paula Turicchi	2.4	6/1/2012							Y
13.13	WISH Nursing Director and Chief Nursing Officer (CNO) must ensure all nursing personnel working within scope of practice.	Jackie Brock John Raish	4.3	4/13/2012							Y
13.14	Nursing Directors of each area should review competencies required for the care of their patient population in accordance with nursing practice standards.	Emilie Allen	4.4	6/1/2012							Y

Women and Infant's Specialty Health (WISH) (Section 2.13)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
13.15	A full assessment of current staff should be conducted to establish a current baseline of competencies.	Emilie Allen	4.4	7/13/2012							
13.16	Review all personnel files for completed competencies.	Emilie Allen	4.4	7/13/2012							
13.17	Gaps identified in competencies should be addressed with education and audit.	Emilie Allen	4.4	7/13/2012							
13.18	Conduct newborn resuscitation competency education and audit.	Emilie Allen	4.4	7/13/2012							Y
13.19	Evaluate the need for an additional FTE's to assist in the responsibility of supply stocking, storage, and environmental rounds on all WISH units.	Paula Turicchi	2.4	5/31/2012							Y
13.20	Establish recommended AORN practices of setting up the sterile back table for delivery table set-up. Determine if additional staffing is required for L&D OR and LDR for sterile supply set up. Hire additional staff, if needed.	Suzanne Sims	2.5	4/13/2012							Y
~~**13.21**~~	~~Ensure plan of care practices are standardized and followed regularly.~~	~~Barbara Mims Valerie Harvey~~	~~4.2~~	~~8/10/2012~~							
~~**13.22**~~	~~Standardize hand off procedures. Educate staff.~~	~~Barbara Mims Valerie Harvey~~	~~4.2~~	~~8/15/2012~~							
13.23	Women Infant and Specialty Health (WISH) operations and nursing leadership with Chief Nursing Officer (CNO) to develop plan and budget for required changes.	Paula Turicchi	2.4	6/8/2012							Y
13.24	Present plan to senior leadership.	Paula Turicchi	2.4	5/25/2012							Y
13.25	Design care model that provides for rooming-in options for infants.	Jackie Brock John Raish	4.3	6/30/2012							Y
13.26	Establish a census tracking tool for newborns.	Paula Turicchi	2.4	5/11/2012							Y
13.27	Review and revise infant security and abduction plan.	Paula Turicchi	2.4	4/6/2012							Y
13.28	Conduct at least one Code Pink drills per year.	Emilie Allen	4.4	5/11/2012							Y
13.29	Identify space that can be made available for emergency equipment within the post partum unit (department reports plan underway to convert treatment rooms for this purpose).	Paula Turicchi	2.4	7/31/2012							

Women and Infant's Specialty Health (WISH) (Section 2.13)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
13.30	Establish monthly mock equipment drills and verify emergency equipment is immediately available where newborns are housed.	Paula Turicchi	2.4	7/31/2012							
13.31	Discard all "six pack" transport carts.	Paula Turicchi	2.4	4/6/2012							Y
13.32	Conduct a multidisciplinary assessment of conditions of WISH units related to supplies/medications including refrigeration, cleanliness, appropriate storage of supplies, and other conditions related to infection prevention.	Paula Turicchi	2.4	4/15/2012							Y
~~**13.33**~~	~~Evaluate the need for an additional FTE's to assist in the responsibility of supply stocking, storage, and environmental rounds on all WISH units.~~	~~Paula Turicchi~~	~~2.4~~	~~5/4/2012~~							
13.34	Establish an alternative protocol for delivery table set-up to ensure sterile field.	Suzanne Sims	2.5	4/6/2012							Y
13.35	Educate staff on storage requirements for specimens.	Emilie Allen	4.4	4/27/2012							Y
13.36	Revise dirty utility room flow and practice.	Paula Turicchi	2.4	7/15/2012							
13.37	Department reports a plan is in progress for construction to ensure proper dirty utility room flow. (No start date supplied)	John Dragovits	1.7	7/12/2012							
13.38	Review Parkland policy on securing medications PHR-D-067 Inventory Management – Procurement, Storage	Anne Tudhope Judy Herrington Vicki Crane	4.5	5/18/2012							Y
13.39	Anesthesia medication trays should be stored in a locked, secure area.	Anne Tudhope Judy Herrington Vicki Crane	4.5	4/13/2012							Y
13.40	Store floor stock in Pyxis.	Anne Tudhope Judy Herrington Vicki Crane	4.5	4/13/2012							Y
13.41	Educate staff on the importance of two patient identifiers and include in initial and annual competencies.	Emilie Allen	4.4	3/31/2012							Y
13.42	Educate staff of National Patient Safety Goals and Hospital policy.	Emilie Allen	4.4	3/30/2012							Y

#	Audit/Measures	Responsibility		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Percentage of completed competencies for all WISH staff	**WISH**		**100.0%**							
2	Compliance to Infection Prevention practice	**WISH**		**98.0%**				**96.7%**			

Women and Infant's Specialty Health (WISH) (Section 2.13)										
#	Metric	Responsibility	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Labor productivity (Staffing to include acuity)	WISH								
2	Staffing hours per patient day	WISH	11.65		12.14	13.22	12.95	13.10		
3	Number of days per month staffing ratios were above/below grid	WISH								
4a	Hallway and Classroom Beds in use in L&D (avg duration in minutes)	WISH	113.65		111.92	120.00	117.10	114.14		
4b	Hallway and Classroom Beds in use in L&D (instances)	WISH	136		52	49	62	123		
5	Patient double-up on Post-Partum	WISH	54.0%		46.1%	41.8%	38.6%	34.5%		
6	Induction Interruption	WISH								
7	Induction Delay	WISH								
8	Direct Admits to Post-Partum	WISH								
9	Bounce-Back from Post-Partum to L&D Recovery	WISH								

Comments

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Perioperative Services (Section 2.14)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
14.01	Conduct daily infection control audits in all areas of the Main OR, PACU, PreOp Holding, DSU, Anesthesia Workroom, ASC and PAEC.	Suzanne Sims	2.5	8/31/2012							
14.02	Execute the progressive disciplinary action and performance improvement plan for staff/physicians who exhibit failure to follow infection prevention policies and procedures.	Suzanne Sims	2.5	6/8/2012							Y
14.03	Conduct environment of care rounds every shift in each perioperative area.	Suzanne Sims	2.5	8/31/2012							
14.04	Review and follow Parkland policy Admin 6-33 “Labeling of Medications On/Off the Sterile Field”.	Suzanne Sims	2.5	8/31/2012							
14.05	Review and follow Parkland policy Admin 6-43, “Using Two (2) Patient Identifiers”.	Suzanne Sims	2.5	8/31/2012							
14.06	Provide training for alternative options for medication solution transfer.	Suzanne Sims	2.5	7/13/2012							Y
14.07	Conduct daily audits of various medication management measures to determine compliance.	Suzanne Sims	2.5	8/31/2012							
14.08	Review and follow the Parkland policy Admin 6-30 “Universal Policy”.	Suzanne Sims	2.5	7/13/2012							
14.09	Conduct daily audits of various patient right initiatives to determine compliance: Critical Equipment MH Cart/Drugs Difficult Airway Cart	Suzanne Sims	2.5	6/30/2012							

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Compliance to using two patient identifiers [1]	**Surgery**						**100.00%**			
2	Compliance percentage of Infection Prevention by audit, monthly [1]	**Surgery**		**98.0%**				**97.60%**			
3	Compliance percentage of Environment of Care by audit, monthly	**Surgery**		**100%**							
4	Compliance to site marking procedure [1]	**Surgery**		**100%**				**99.77%**			
5	Compliance to medication management measures (labeling, transferring from the circulator to scrub, securing and other measures) [1]	**Surgery**		**100%**				**98.99%**			
6	Compliance with critical equipment	**Surgery**									
7	Compliance to Time Out procedure [1]	**Surgery**		**100%**				**99.76%**			

Perioperative Services (Section 2.14)

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of medication errors	Surgery		0	9	7	5	2		
2	Number of blood transfusion errors	Surgery								
3	Number of incorrect consents	Surgery								
4	Number of wrong site surgeries or wrong site markings	Surgery								
5	Number of lab specimen mis-labeling	Surgery								
6	Percentage of travelers - OR	Surgery			11.8%	9.5%	10.7%	9.5%		
7	Surgical Site infection rate (2 month lag)	Surgery	1.71%	0%				1.5%		

Comments

1. A&M has yet to validate these figures. Results are currently self-reported.

Task/initiative largely on schedule for completion
Task/initiative may be delayed from Target Date completion
Task/initiative is past the Target Date deadline
Initiative tracking not yet started

Procedural Services - Catherization Lab/Endoscopy (Section 2.15)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
15.01	Conduct a weekly environment of care tour to ensure infection prevention measures are in compliance.	Kim McCloud Linda Licata Barbara Mims	2.7	4/15/2012							Y
15.02	Conduct audit on invasive procedures in the restricted procedure rooms on the proper medication management on and off the sterile field.	Suzanne Sims	2.5	6/30/2012							
15.03	Review Parkland's policy on Surgical Attire and OSHA regulation on Personal Protective Equipment.	Suzanne Sims	2.5	8/31/2012							Y
15.04	Cardiologist performing the procedure to conduct the “pause” to ensure surgical team is properly attired.	Suzanne Sims	2.5	8/31/2012							
15.05	Conduct an education program and competency on maintaining the sterile field.	Suzanne Sims	2.5	8/31/2012							
15.06	Conduct an audit to ensure compliance with surgical attire policy.	Suzanne Sims	2.5	8/31/2012							
15.07	Nurse manager to develop daily EOC tool/checklist to ensure compliance.	Kim McCloud Linda Licata Barbara Mims	2.7	6/8/2012							Y
15.08	Review PHHS policy Admin 6-33 and PS 04-33 on proper handling of medications.	Suzanne Sims	2.5	3/30/2012							Y
15.09	Educate staff of the existing Parkland Universal Protocol policy.	Suzanne Sims	2.5	7/13/2012							
15.10	Develop Time Out procedure “flash cards” to be used as a help guide.	Suzanne Sims	2.5	8/31/2012							
15.11	Conduct an audit on Time Out on all invasive procedures.	Suzanne Sims	2.5	8/31/2012							
15.12	Provide mandatory education on proper site marking to all new and existing physicians. Provide education to staff nurses and techs to ensure they understand the proper site marking requirement based on NPSG.	Suzanne Sims	2.5	8/31/2012							
15.13	Review Parkland's policy PS 04-43 regarding sponge and sharp counts.	Suzanne Sims	2.5	8/31/2012							
15.14	Surgical Services to provide an educational session on the proper procedure of conducting sponge and needle/sharp counts. Develop and implement an annual competency on proper procedure on performing counts.	Emilie Allen	4.4	4/20/2012							Y
15.15	Develop and implement a dashboard key measure all the required elements on correct counts to include instruments and sponges.	Suzanne Sims	2.5	8/30/2012							
15.16	Review Parkland policy Admin 6-33 and PS 04-33 on proper handling of medications.	Suzanne Sims	2.5	3/30/2012							Y
15.17	Develop unit specific medication management competencies.	Emilie Allen	4.4	4/20/2012							Y
15.18	Initiate an awareness program verifying the medication they transfer on and off the sterile field.	Suzanne Sims	2.5	4/27/2012							Y
15.19	Conduct audit to assure needles and syringes are being stored in a safe and proper place and incorporate into daily environmental rounds.	Suzanne Sims	2.5	8/31/2012							
15.20	Audit proper transfer and verifying of medications on/off sterile field.	Suzanne Sims	2.5	6/30/2012							
15.21	Add medication management to the key measures to department quality dashboard.	Suzanne Sims	2.5	6/8/2012							
15.22	Establish action plan for non-compliance.	Suzanne Sims	2.5	6/30/2012							
15.23	Enter the procedural nurse hand off communication to the recovery nurse into Epic.	Barbara Mims Valerie Harvey	4.2	8/15/2012							

Procedural Services - Catherization Lab/Endoscopy (Section 2.15)

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Compliance percentage to Infection Prevention practice [1]	Surgery	98%				99.00%		
2	Compliance percentage of environment of care by audit, monthly	Surgery							
3	Compliance to site marking procedure in cath lab by audit [1]	Surgery					100.00%		
4	Compliance to Time Out procedure by audit [1]	Surgery					98.22%		
5	Compliance to sponge, needle, sharp and instrument count in cath lab	Surgery							
6	Compliance to medication management measures (labeling, transferring from the circulator to scrub, securing and other measures) by audit [1]	Surgery					99.52%		
7	Compliance to using two patient identifiers by audit [1]	Surgery					94.59%		
8	Compliance to proper scrub attire and sterile gowning in restricted areas in cath lab by audit [1]	Surgery					99.56%		

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of wrong site surgeries	Surgery								
2	Number of incorrect consents	Surgery								
3	Number of medication errors	Surgery		0	0	0	1	1		
4	Number of lab specimen mis-labeling	Surgery								
5	Number of return to surgery for retained objects	Surgery								
6	Percentage of blood stream infections	Surgery		0.0%			0.0%	0.0%		

Comments

15.05, 15.11 - 15.13 - Audits in process, results not yet available, physician education delayed due to infrastructure
Although majority of initiatives are complete, Parkland is still experiencing issues in medication administration in GI Lab

1. A&M has yet to validate these figures. Results are currently self-reported.

Task/initiative largely on schedule for completion
Task/initiative may be delayed from Target Date completion
Task/initiative is past the Target Date deadline
Initiative tracking not yet started

Radiology (Section 2.16)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
16.01	Perform demand to capacity, throughput process workflow assessment and labor productivity analysis.	Jenni Burnes	2.2	7/13/2012							
16.02	Define the current backlog of appointment needs and additional capacity to meet backlog.	Jenni Burnes	2.2	3/23/2012							Y
16.03	Provide assessment of rate limiting factors contributing to the backlog.	Jenni Burnes	2.2	4/6/2012							Y
16.04	Develop a current state process workflow diagram.	Jenni Burnes	2.2	5/4/2012							Y
16.05	Develop future process work flow state.	Jenni Burnes	2.2	5/4/2012							Y
16.06	Conduct a labor productivity benchmarking.	Jenni Burnes	2.2	4/20/2012							Y
16.07	Pilot future state process work flow model.	Jenni Burnes	2.2	7/13/2012							
16.08	Provide training.	Jenni Burnes	2.2	7/13/2012							
16.09	Implement the new process flow department wide	Jenni Burnes	2.2	7/13/2012							
16.10	Review of the existing Parkland "time out" policy to ensure clarification of required process and/or revise as appropriate.	Suzanne Sims	2.5	6/1/2012							
16.11	Provide Time Out procedure “flash cards” to be used as a help guide until newly learned behavior has been established and is codified.	Suzanne Sims	2.5	8/31/2012							
16.12	Establish Time Out procedure as a one of the competencies of personnel.	Emilie Allen	4.4	5/11/2012							Y
16.13	Execute progressive counseling/disciplinary action plan for infractions.	Jenni Burnes	2.2	6/8/2012							Y
16.14	Development of Time Out dashboard metrics for dashboard and reporting of metrics to departmental QAPI.	Jackie Sullivan	6.4	7/31/2012							
16.15	Ensure needles and syringes are secured in an area that is not accessible to unauthorized persons.	Jenni Burnes	2.2	7/13/2012							
16.16	Review Parkland policy on medications on and off the sterile field.	Suzanne Sims	2.4	8/31/2012							
16.17	Review Parkland policy on labeling medications on and off the sterile field.	Suzanne Sims	2.4	8/31/2012							
16.18	Develop and review the smart order sets that have foley insertions to determine whether Lidocaine jelly should be added.	Anne Tudhope Judy Herrington Vicki Crane	4.5	7/13/2012							Y
16.19	Review Parkland policy on properly securing medications.	Anne Tudhope Judy Herrington Vicki Crane	4.5	3/23/2012							Y
16.20	Develop an annual department-specific medication competency on all staff	Emilie Allen	4.4	6/8/2012							Y
16.21	Assign role and responsibilities to ensure all tasks including the disposal of opened and unused supplies to Interventional Radiology (IR) tech.	Jenni Burnes	2.2	5/11/2012							Y
16.22	Distribute Parkland Policy G-1 on radiation safety.	Jenni Burnes	2.2	4/6/2012							
16.23	Develop annual unit specific competency on radiation safety competency for all staff, physicians and vendors.	Jenni Burnes	2.2	6/29/2012							
16.24	Audit the Main and ASC Operating Room staff and providers proper wear of personal protective attire during a procedure when operating the mini-fluoroscopy and other radiation safety requirements.	Jenni Burnes	2.2	9/14/2012							Y
16.25	Initiate the education plan for the physicians requiring the need to meet the credentialing criteria.	Patricia Bergen, MD	5.1	5/4/2012							Y

Radiology (Section 2.16)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
16.26	Collate all credentialing documents and provide to the committee for review and approval.	Patricia Bergen, MD	5.1	5/11/2012							Y
16.27	Ensure a person who is approved to operate the mini-fluoroscopy unit is in procedures where the surgeon has not been granted privileges.	Jenni Burnes	2.2	6/8/2012							Y
16.28	Develop an interface or investigate on how to tie in an alert of physician's privileges at point of scheduling a procedure.	Jenni Burnes	2.2	6/8/2012							Y
16.29	Inquire and implement a functionality in Epic for the ordering physician to cognitively select whether to use the establish protocol or use orders as written.	Jenni Burnes	2.2	9/14/2012							Y

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Compliance to use of two patient identifiers [1]	**Radiology**		**100%**			**100.0%**	**100.0%**			
2	Compliance to the Time Out procedure [1]	**Radiology**		**100%**			**99.7%**	**100.0%**			
3	Compliance to proper securing of medications and medication supplies (needles, syringes) [1]	**Radiology**		**100%**			**86.0%**	**91.0%**			
4	Compliance to medication management (labeling, scrub and circulator exchange) [1]	**Radiology**		**100%**			**95.9%**	**98.7%**			

Radiology (Section 2.16)										
#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Labor productivity by each modality (paid hours/unit of service)									
	Mammography - Diagnostic	Radiology	0.5	0.5			0.6	0.5		
	MRI	Radiology	1.9	1.9			1.8	1.9		
	CT	Radiology	0.7	0.7			0.6	0.6		
	US	Radiology	0.8	0.8			0.8	0.7		
	IR	Radiology	1.2	1.2			1.6	1.9		
2	Number of days to next third available appointment (Mammography, US, MRI)									
	Mammography - Diagnostic	Radiology	95	14	104	101	95	119		
	MRI	Radiology	64	14	57	47	52	24		
	CT	Radiology	12	14	27	27	13	0		
	US	Radiology	15	14	11	11	12	2		
	IR	Radiology	26	14	25	18	18	18		
3	Number of Incorrect consents	Radiology		0			1	0		
4	Number of incorrect tests or wrong results placed	Radiology		0			0	0		
5	Number of cancelled surgeries due to unavailable films	Radiology		0						
6	Number of medication errors	Radiology		0	2	0	2	2		
7	Number of lab specimen mis-labeling	Radiology		0						
8	Current utilization of radiology slots									
	Mammography - Diagnostic	Radiology	130%	125%			125%	136%		
	MRI	Radiology	115%	130%			118%	123%		
	CT	Radiology	117%	120%			130%	134%		
	US	Radiology	118%	120%			121%	121%		
	IR	Radiology	116%	120%			112%	127%		
9	Number of wrong site surgeries	Radiology		0						

Comments

16.22 - 16.23 - Audits in process, results not yet available, physician education delayed due to infrastructure

1. A&M has yet to validate these figures. Results are currently self-reported.

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Laboratory Services (Section 2.17)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
17.01	Develop education plan for phlebotomy staff including new orientees.	Jenni Burnes	2.2	3/30/2012							Y
17.02	Conduct random audits of phlebotomy carts.	Jenni Burnes	2.2	5/11/2012							
17.03	Ensure there is a regular cleaning schedule with EVS for the affected Laboratory areas.	Kim McCloud Linda Licata Barbara Mims	2.7	4/6/2012							Y
17.04	Establish environment of care rounds with EVS and Infection control leaders.	Kim McCloud Linda Licata Barbara Mims	2.8	4/6/2012							Y
17.05	Initiate department-level Infection Control accountability and metrics.	Kim McCloud Linda Licata Barbara Mims	2.8	5/15/2012							Y
17.06	Educate laboratory staff on expected cleaning standards and schedules.	Jenni Burnes	2.2	4/13/2012							Y
17.07	Define with EVS an escalation process for cleaning.	Kim McCloud Linda Licata Barbara Mims	2.7	4/13/2012							Y
17.08	Utilize reagent that requires validation of results prior to testing.	Jenni Burnes	2.2	3/23/2012							Y
17.09	Lab Director will develop an education plan and competency to ensure all current employees and new hires understand the confirmation process prior to individual patient reporting.	Jenni Burnes	2.2	6/8/2012							Y
17.10	Listen to periodic transcription tapes to ensure transcriptionist is reporting variances.	Jenni Burnes	2.2	5/25/2012							Y
17.11	Review Parkland reporting critical value policy.	Jenni Burnes	2.2	4/13/2012							Y
17.12	Develop and implement an education plan and competencies on critical value reporting.	Jenni Burnes	2.2	4/13/2012							
17.13	Monitor the effectiveness of the education program with the turnaround time of the critical value reporting.	Jenni Burnes	2.2	7/31/2012							
17.14	Review Parkland policy Admin 6-30 Universal Protocol.	Suzanne Sims	2.5	8/31/2012							
17.15	Conduct five weekly random Time Out observations in the FNA clinic.	Jenni Burnes	2.2	6/8/2012							Y
17.16	Collect Time Out observation results and add to clinic QAPI indicators.	Jenni Burnes	2.2	5/11/2012							Y
17.17	Retrain current staff to ensure awareness of the availability of the ALVIN video translator or the language line for patients that require a certified translator.	Jenni Burnes	2.2	6/8/2012							Y
17.18	Provide Medical Assistant staffing for FNA clinic.	Jenni Burnes	2.2	6/8/2012							Y

Laboratory Services (Section 2.17)

#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
17.19	Meet with MIO and an Epic representative to enhance Epic documentation to "hardwire" autopsy documentation requirements.	Jenni Burnes	2.2	4/27/2012							Y
17.20	Add autopsy documentation requirements to dictation template, including pathology checklist.	Jenni Burnes	2.2	6/8/2012							Y
17.21	Educate morgue staff on required two identifier process and their empowerment to stop the autopsy without proper consent.	Emilie Allen	4.4	4/6/2012							Y
17.22	Perform audit of autopsy records for evidence of family communication, pathology notification by nursing, consent, and any other required elements.	Jenni Burnes	2.2	6/8/2012							Y

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Compliance to accession and grossing the specimen by audit [1]	**Lab**		**100%**		**100%**	**100%**	**100%**			
2	Compliance to the use of the two patient identifiers with transcription post specimen processing by audit [1]	**Lab**		**100%**		**100%**	**100%**	**100%**			
3	Compliance to autopsies having formal orders [1]	**Lab**		**100%**		**38%**	**100%**	**100%**			
4	Number of mislabeled specimen by unit/clinic	**Lab**		**0**							
5	Compliance to staffing grid										

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of incorrect reporting of lab/pathology results	**Lab**		**0**						
2	Percent compliance to 60 minute critical value turnaround time [1]	**Lab**		**100.0%**		**98.0%**	**100.0%**	**99.0%**		

Comments

17.12 - Audits in process, results not yet available, physician education delayed due to infrastructure

1. A&M has yet to validate these figures. Results are currently self-reported.

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Food & Nutrition Services (Section 2.18)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
18.01	Change procedure to ensure all unused trays are collected after meals.	Jenni Burnes	2.2	5/30/2012							Y
18.02	Educate nursing staff to communicate with F&NS to re-order or hold a tray if a patient is not available for a meal.	Kim McCloud	2.8	4/13/2012							Y
18.03	Acquire thermometers for freezers.	Jenni Burnes	2.2	4/4/2012							Y

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Compliance with freezer temperature ranges for patient refrigerators	FNS		100%			100%	100%			
2	Compliance with all patient are proper temperature controlled food	FNS		100%			100%	100%			

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Number of returned "uneaten" trays	FNS									
2	Number of "rescheduled" tray orders for patients	FNS									

Comments

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Organ and Tissue (Section 2.19)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
19.01	Develop a process to ensure Organ Procurement quality improvement functions are reported to QCC regularly.	Jackie Sullivan	6.4	9/14/2012							
19.02	Develop documentation for annual training program attendance.	Emilie Allen	4.4	9/14/2012							Y

Comments	
	Task/initiative largely on schedule for completion Task/initiative may be delayed from Target Date completion Task/initiative is past the Target Date deadline Initiative tracking not yet started

Physical Medicine and Rehabilitation (PMR) (Section 2.20)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
20.01	Conduct an assessment of the factors contributing to the backlog to include: demand vs. capacity, current space and labor productivity.	Jenni Burnes	2.2	4/20/2012							Y
20.02	Upon completing elements of the assessment, develop an overall "current state" process work flow diagram noting process failures and operational barriers.	Jenni Burnes	2.2	5/4/2012							Y
20.03	Analyze current staffing patterns and address shortages.	Jenni Burnes	2.2	5/4/2012							Y
20.04	Redesign future process flows to address identified barriers.	Jenni Burnes	2.2	6/29/2012							Y
20.05	Complete pilot of revised process flow to assess effectiveness and any additional needed changes.	Jenni Burnes	2.2	6/29/2012							Y
20.06	Develop targeted improvement levels: for backlog, patient and physician communication, productivity, etc. to assess impact of changes. A consistent tool to assess effectiveness is needed to ensure consistency in assessing progress.	Jenni Burnes	2.2	6/29/2012							Y
20.07	Identify core requirements for assessment and documentation for proper patient care and educate staff.	Barbara Mims Valerie Harvey	4.2	8/1/2012							
20.08	Develop a methodology to ensure all elements of care have been addressed and assessed.	Jenni Burnes	2.2	6/8/2012							Y
20.09	Establish key metrics for inpatient rehab.	Jenni Burnes	2.2	5/25/2012							
20.10	Develop methodology to track required metrics are being reported.	Jenni Burnes	2.2	9/14/2012							
20.11	Determine legal requirements for DME license.	Jody Springer	1.2	4/13/2012							Y
20.12	Determine methodology dispensing DME (hospital vs. contract supplier).	Jody Springer	1.2	4/20/2012							
20.13	Develop and implement Infection Prevention training.	Kim McCloud Linda Licata Barbara Mims	2.8	4/13/2012							Y
20.14	Non–compliance with proper infection control procedures should be addressed immediately and ongoing non-compliance should result in progressive disciplinary action.	Jenni Burnes	2.2	6/8/2012							Y
20.15	Develop methodology to track wound care infection rates.	Jenni Burnes	2.2	5/4/2012							Y

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	
1	Percent of all elements of care that have been assessed and addressed [1]	**PMR**				**95.12%**	**91.30%**	**90.10%**			

Physical Medicine and Rehabilitation (PMR) (Section 2.20)									
#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Labor productivity (percentage of targeted appointments per FTE)									
	OT	PMR	87.5%	100.0%	78.3%	81.5%	93.6%	81.4%		
	PT	PMR	61.1%	100.0%	60.9%	62.1%	66.7%	69.7%		
	ST	PMR	71.9%	100.0%	74.2%	86.9%	95.4%	75.8%		
2	Infection frequency	PMR						1		
3	Percentage of expired orders (patients that did not receive treatment within 60 days of physician order)									
	OT (2 month lag)	PMR	13.8%	0.0%			13.1%	15.7%		
	PT (2 month lag)	PMR	27.0%	0.0%			27.4%	33.0%		
	ST (2 month lag)	PMR	25.4%	0.0%			12.1%	26.7%		
4	No show rate									
	OT	PMR	15.2%	10.0%	15.8%	13.9%	14.7%	15.0%		
	PT	PMR	15.6%	10.0%	16.9%	15.0%	16.1%	13.8%		
	ST	PMR	13.8%	10.0%	15.0%	10.0%	7.8%	12.8%		

Comments

1. A&M has yet to validate these figures. Results are currently self-reported.

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

Respiratory Therapy (Section 2.21)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
21.01	Analyze staffing levels and provided recommendations.	Jenni Burnes	2.2	4/13/2012							Y
21.02	Adjust staffing and/or shifts to agreed upon staffing grid.	Jenni Burnes	2.2	5/11/2012							Y
21.03	Develop targeted improvement in missed treatments and a timeline for expected improvements.	Jenni Burnes	2.2	3/22/2013							Y
21.04	Explore the ability to analyze missed treatments per shift through Epic.	Jenni Burnes	2.2	4/13/2012							Y
21.05	Determine a mechanism to track "assigned, completed, and missed" by therapist through a daily shift report document.	Jenni Burnes	2.2	6/8/2012							Y
21.06	Documentation educational program for all Respiratory Therapy (RT) staff.	Jenni Burnes	2.2	6/8/2012							Y
21.07	Initiate documentation review process to ensure patient quality of care.	Jenni Burnes	2.2	9/14/2012							
21.08	Initiate patient rounds to obtain feedback regarding effectiveness of respiratory treatments.	Jenni Burnes	2.2	9/14/2012							
21.09	Review the current oxygen tank use, storage, and refilling procedure for gaps in guidance to both RT staff as well as other clinicians.	Kim McCloud Linda Licata Barbara Mims	2.7	4/6/2012							Y
21.10	Meet with clinical leaders who store oxygen tanks and determine responsibilities of staff in which oxygen tanks are stored.	Kim McCloud Linda Licata Barbara Mims	2.7	4/13/2012							Y
21.11	Develop a house-wide education/awareness for all staff that addresses all areas of responsibility.	Kim McCloud Linda Licata Barbara Mims	2.7	5/11/2012							Y
21.12	Audits of oxygen tank safety.	Kim McCloud Linda Licata Barbara Mims	2.7	5/1/2012							Y
21.13	Long term strategy for an annual assessment of therapy care to ensure that there are no gaps in process or care.	Jenni Burnes	2.2	9/14/2012							

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Percentage of missed treatments related to Therapist not being available [1]	**RT**	**0%**		**12.2%**	**9.8%**	**4.2%**		
2	Respiratory Care documentation accuracy [1]	**RT**	**95.0%**				**87.7%**		
3	Compliance in oxygen tank storage	**House-wide**	**100%**			**99.5%** [1]	**75.0%** [2]		

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Productivity Metrics (Weighted Procedures/Hours Paid)	**RT**	**2.74**	**2.65**	**2.98**	**2.73**	**2.58**	**3.04**		
2	Ventilator Associated Pneumonia Rate	**RT**	**3.29%**	**1.8%**		**4.5%**	**0.4%**	**3.5%**		

Respiratory Therapy (Section 2.21)	
Comments	
1. A&M has yet to validate these figures. Results are currently self-reported. 2. Audit result is reported by A&M. There were 5 instances of improper tank storage out of 20 audits.	Task/initiative largely on schedule for completion Task/initiative may be delayed from Target Date completion Task/initiative is past the Target Date deadline Initiative tracking not yet started

Community Oriented Primary Care (COPC) (Section 2.22)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
22.01	Develop medication documentation training program for all staff responsible for medication administration.	Anne Tudhope Judy Herrington Vicki Crane	4.5	6/8/2012	●	●	●	●			Y
22.02	Develop and implement processes to reconcile controlled substances in Medlock clinic.	Vivian Johnson Dr. Shannon	2.3	3/23/2012	●	●	●	●			Y
22.03	Develop and implement audit tool to track controlled substance reconciliation.	Anne Tudhope Judy Herrington Vicki Crane	4.5	5/11/2012	●	●	●	●			Y
22.04	Implement electronic medical record (EMR)/Pharmacy interface to allow for Pharmacy to provide oversight to prescribing and administration at correctional facilities visited by the mobile clinic.	Vivian Johnson Dr. Shannon	2.3	6/20/2012	●	●	●	●			Y
22.05	Review results of Medicine specialty clinic pilot and determine viability of implementation to other clinics for medication reconciliation solution.	Anne Tudhope Judy Herrington Vicki Crane	4.5	5/11/2012	●	●	●	●			Y
22.06	Formulate alternative solution to medication reconciliation issue.	Anne Tudhope Judy Herrington Vicki Crane	4.5	5/11/2012	●	●	●	●			Y
22.07	Empower and educate staff on basic standards related to environment of care and the normal chain of command for addressing issues as they arise. Also include a process on issue escalation when issues are not addressed.	Jessica Hernandez Holt Oliver, MD	3.6	4/6/2012	●	●	●	●			Y
22.08	Create comprehensive environment of care gaps.	Jessica Hernandez Holt Oliver, MD	3.6	6/8/2012	●	●	●	●			Y
22.09	Meet with the appropriate leaders responsible for environmental cleaning and maintaining the environment to discuss the gaps and develop plan for improvement.	Kim McCloud Linda Licata Barbara Mims	2.7	5/11/2012	●	●	●	●			Y
22.10	Establish multi-disciplinary monitoring of clinic locations.	Kim McCloud Linda Licata Barbara Mims	2.7	6/8/2012	●	●	●	●			Y
22.11	Load plans of care into Jail electronic medical record (EMR).	Jessica Hernandez Holt Oliver, MD	3.6	6/8/2012	●	●	●	●			Y

Community Oriented Primary Care (COPC) (Section 2.22)

#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
22.12	Conduct training for staff on plan of care standards and proper documentation and individualized plan of care.	Barbara Mims Valerie Harvey	4.2	8/1/2012	●	●	●	●			
22.13	Conduct a chart audit to evaluate staff compliance regarding plan of care process.	Jessica Hernandez Holt Oliver, MD	3.6	6/8/2012	●	●	●	●			Y
22.14	Develop a process for patients who do not have a common diagnosis and their plan of care.	Barbara Mims Valerie Harvey	4.2	7/20/2012	●	●	●	●			Y

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Compliance with medication management to include but not limited to securing, labeling , reconciliation and documentation	**COPC**							
2	Compliance percentage of environment of care by audit, monthly	**COPC**					**95.53%**		
3	Compliance to the use of two patient identifiers	**COPC**							
4	Compliance to infection prevention practice	**COPC**							
5	Number of completed medication reconciliations by audit	**COPC**							

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of medication errors	**COPC**		**0**	**7**	**2**	**1**	**1**		
2	Number of lab specimen mis-labeling by clinic	**COPC**								
3	Third next available appointment	**COPC**				**92.6**	**91.6**	**88.8**		
4	No show rate	**COPC**				**81.7%**	**81.9%**			
5	Number of narcotic discrepancies at the jail	**COPC**								

Comments

● Task/initiative largely on schedule for completion
● Task/initiative may be delayed from Target Date completion
● Task/initiative is past the Target Date deadline
● Initiative tracking not yet started

Specialty Clinics (Section 2.23)

#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
23.01	Ensure "hard-stop" process in Epic is engaged.	Vivian Johnson	2.3	9/14/2012	🟢	🟢	🟢	🟢			Y
23.02	Determine EVS scope and schedule.	Jessica Hernandez Holt Oliver, MD	3.6	3/30/2012	🟢	🟢	🟢	🟢			Y
23.03	Clinic leadership to round clinic areas to monitor PHI security.	Jessica Hernandez Holt Oliver, MD	3.6	6/8/2012	⚫	🟢	🟢	🟢			Y
23.04	Clinic leadership to develop and implement disciplinary actions for staff violations of HIPAA policies.	Jessica Hernandez Holt Oliver, MD	3.6	5/7/2012	⚫	🟢	🔴	🟢			Y
23.05	Develop clinic-wide training and awareness program for proper time-out procedure.	Suzanne Sims	2.5	7/31/2012	🟢	🟢	⚫	🟢			
23.06	Conduct time-out training for all areas where patient procedures are performed.	Suzanne Sims	2.5	9/14/2012	🟢	🟢	⚫	🟢			

#	Audit/Measures	Accountability		Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Compliance with medication management to include but not limited to securing, labeling , reconciliation and documentation	**Clinic**								
2	Compliance percentage of environment of care by audit, monthly	**Clinic**						**94.22%**		
3	Compliance to the use of two patient identifiers	**Clinic**								
4	Number of completed medication reconciliations by audit	**Clinic**								

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of medication errors	**Clinic**		**0**	**0**	**2**	**2**	**0**		
2	Number of lab specimen mis-labeling by clinic	**Clinic**								
3	Number of PHI breach	**Clinic**								
4	Third next available appointment	**Clinic**								
5	No show rate by clinic	**Clinic**								
6	Number of completed work orders (EVS, Facilities, and Clinical Engineering)	**Clinic**								

Comments

🟢 Task/initiative largely on schedule for completion
🟡 Task/initiative may be delayed from Target Date completion
🔴 Task/initiative is past the Target Date deadline
⚫ Initiative tracking not yet started

Contract Services (Section 2.24)											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
24.01	Create database of all contracted patient service arrangements.	Muthusamy Anandkumar, MD Ciel Murphy	6.5	3/22/2013							
24.02	Review department specific quality indicators for all contracts.	Muthusamy Anandkumar, MD Ciel Murphy	6.5	6/1/2012							Y
24.03	Request quality monitors from vendors who have not supplied them.	Muthusamy Anandkumar, MD Ciel Murphy	6.5	6/1/2012							Y
24.04	Determine Parkland specific quality indicators for each contract.	Muthusamy Anandkumar, MD Ciel Murphy	6.5	7/31/2012							
24.05	Each department to report contract monitoring elements at the department's next regularly scheduled reporting appointment.	Muthusamy Anandkumar, MD Ciel Murphy	6.5	7/31/2012							
24.06	Review all contracts using department specific indicator list. Each department to have a specific list of all contracts, appropriate indicators, and existence of indicators.	Muthusamy Anandkumar, MD Ciel Murphy	6.5	7/31/2012							
24.07	Contract Management Unit to provide a schedule of all contracted services affecting patient care to the BOM Quality Committee along with a template on how contracts will be scored for quality.	Muthusamy Anandkumar, MD Ciel Murphy	6.5	3/22/2013							Y
24.08	Contract Management Unit to provide first batch of contracts for quality score and review – and proposed scores against template – to BOM Quality Committee.	Muthusamy Anandkumar, MD Ciel Murphy	6.5	6/8/2012							Y

Contract Services (Section 2.24)

#	Audit/Measures	Accountability	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Percent of current contracts in the database	Contracts				100%	100%		
2	Percent of current contracts that have department specific quality indicators	Contracts					100%		

#	Metric	Accountability	Baseline	Goal	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12
1	Number of contracts that meet contacting requirements for quality scoring	Contracts					74.0%	20.7%		

Comments

- Task/initiative largely on schedule for completion
- Task/initiative may be delayed from Target Date completion
- Task/initiative is past the Target Date deadline
- Initiative tracking not yet started

QAPI											
#	Tasks/Initiatives	Accountability	Work Stream	Target Date	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Completion
Q.01	Revise QAPI plan · Include CMS elements · Prioritize efforts and resources · Customize indicators to reflect specific patient populations in each department · Define methodology to capture and analyze data · Define formal process for reporting to Quality of Care Committee (QCC) and the BOM Quality Committee. · Identify a regular reporting schedule for each department	Jackie Sullivan	6.1	5/25/2012	●	●	●	●			Y
Q.02	Approval of QAPI plan by the QCC and BOM Quality Committee.	Jackie Sullivan	6.1	5/25/2012	●	●	●	●			Y
Q.03	Capture and analyze baseline data from initial tracers for survey readiness.	Jackie Sullivan	6.1	6/15/2012	●	●	●	●			Y
Q.04	Develop and implement corrective action plan for survey readiness	Jackie Sullivan	6.1	6/30/2012	●	●	●	●			Y
Q.05	Performance Improvement group should implement rounding as a method to collect data for adverse patient events	Jackie Sullivan	6.1	6/30/2012	●	●	●	●			Y
Q.06	Performance Improvement group to develop a list of resources from which to pull adverse patient events	Jackie Sullivan	6.1	7/31/2012	●	●	●	●			
Q.07	Develop methodology to trend, analyze and report adverse patient events	Jackie Sullivan	6.1	7/31/2012	●	●	●	●			
Q.08	Work with A&M to improve RCA process	Jackie Sullivan	6.1	7/31/2012	●	●	●	●			
Q.09	Develop a master report of all RCAs conducted. Include incident date, date of RCA commencement, date of RCA conclusion, general results and actions taken.	Jackie Sullivan	6.1	6/30/2012	●	●	●	●			Y
Q.10	Review standing reports generated by CIS and meet with end users/management to determine relevance and meaningfulness. Discontinue generation of reporting that does not add value to end user/management.	Jackie Sullivan	6.1	5/25/2012	●	●	●	●			Y
Q.11	Establish a schedule for CIS with due dates of all necessary reporting	Jackie Sullivan	6.1	5/25/2012	●	●	●	●			Y
Q.12	~~Patient Safety~~ PCRC to revise and standardize scoring system used to refer cases to peer review	Jackie Sullivan	6.1	5/18/2012	●	●	●	●			
Q.13	Create survey and initial tracers to collect baseline data in the form of a Quality Assessment (QA).	Jackie Sullivan	6.1	6/30/2012	●	●	●	●			Y
Q.14	Complete Quality Assessment survey and tracer work.	Jackie Sullivan	6.1	6/30/2012	●	●	●	●			
Q.15	Complete department-specific Performance Improvement (PI) plan with indicators appropriate for department's patient population.	Jackie Sullivan	6.4	5/25/2012	●	●	●	●			Y
Q.16	Implement corrective actions per department's PI plan.	Jackie Sullivan	6.1	7/31/2012	●	●	●	●			
Q.17	Report PI plan status on at least semi-annual basis to QCC.	Jackie Sullivan	6.1	5/25/2012	●	●	●	●			Y

Comments

Q.14 - Tracer work has not begun yet, data will begin to be collected in July

● Task/initiative largely on schedule for completion
● Task/initiative may be delayed from Target Date completion
● Task/initiative is past the Target Date deadline
● Initiative tracking not yet started